CHILD AND YOUTH MENTAL HEALTH PLAN FOR BRITISH COLUMBIA

Revised July, 2004

EXECUTIVE SUMMARY

Overview

Children are British Columbia's most important investment in the future. Families and communities share the responsibility to ensure that children in British Columbia have access to the resources that promote health, wellbeing and optimal human development. It is our common goal – and in our common interest – to see that children thrive.

Despite everyone's best efforts, however, some children develop serious health problems. Mental illnesses now constitute the most important group of health problems that children suffer – superceding all other health problems in terms of the number of children affected and the degree of impairment caused. Currently, one in seven (more than 140,000) children in British Columbia are estimated to have a mental illness serious enough to cause significant distress and impair their development and functioning at home, at school, and in the community. The majority of these children (and their families) do not receive the services they need, with the result that impairments often continue, causing increased suffering and affecting productivity and functioning in adulthood.

Children's mental health programs and services have evolved in British Columbia as a network of diverse services provided by a variety of practitioners working in community, hospital, and residential care settings. While good efforts have been made over the years to improve services, serious concerns remain. Services have been poorly coordinated and insufficient to meet the needs of British Columbia's children and families. Further, too little attention has been paid to addressing the mental health and developmental needs of children earlier, before the emergence of a severe impairment that could disable a child for life.

The Ministry of Children and Family Development, supported by the Ministry of Health Services, has embarked on a children's mental health planning process in order to address these concerns. As part of this process, a series of consultations were held with community, family and practitioner groups, and a review of the relevant research literature was conducted. The plan outlined here reflects a long-term commitment to improving the resources and outcomes for children's mental health in British Columbia.

To better meet the mental health needs of children new approaches and additional resources are urgently needed. Because the challenge is too large to be met solely by increased clinical services, coordinated approaches are required on several different levels. First, more timely and effective treatment and support

services are needed for children with serious mental illness. Second, programs are needed to reduce risk and prevent and mitigate the effects of mental illness. Third, new efforts are needed to improve the capacities of families and communities to prevent and/or overcome the harmful impact of mental illness in children. Finally, better systems are needed to coordinate services, monitor outcomes, and ensure public accountability for policies and programs. The long-term goal is to improve mental health outcomes for all children in British Columbia.

Providing Treatment and Support

Most of the more than 140,000 children in British Columbia who are suffering with a mental illness at any given time do not receive effective treatment or the support they and their families need, with the result that there are serious long-term costs and consequences for them, as well as for their families and communities.

This plan will improve treatment and support by:

- Ensuring that children (and their families) have access to a core continuum of timely, evidence based, effective mental health assessment and treatment services;

- Ensuring the effective coordination of services across all related sectors including public health and primary care, early child development, schools, community living, child protection, addictions, youth forensics and youth justice, adult mental health, hospitals, and crisis and residential services;

- Promoting evidence-based practice as the standard of care for children's mental health programs and services through providing training and education, and through monitoring standards of practice for all children's mental health practitioners and settings; and

- Providing new resources for early intervention programs for serious mental health problems including anxiety, depression and psychosis.

Reducing Risk

Some children are at greater risk for acquiring a mental illness. These children and their families benefit from targeted efforts to reduce their risk and prevent problems earlier where possible.
This plan will address the issue of risk reduction by:

- Initiating provincial public education programs to facilitate early recognition and preventive intervention to reduce the stigma associated with mental

health problems, and to promote approaches that increase protective factors in the lives of children and families; and

- Providing mental health expert advice and consultation to programs and services across all related sectors including public health and primary care, early child development, schools, community living, child protection, addictions, youth justice, adult mental health, hospitals, and crisis and residential services.

Building Capacity

Mental health, like physical health, is determined by a variety of biological, social, psychological, economic, and other environmental factors. Efforts to improve mental health and treat mental illness must also pay attention to these determinants of health. It is especially important to support and strengthen the positive influence of families and communities. Similarly, it is important to mitigate the potential effects of harmful factors that can occur in a child's environment.

This plan will build family and community capacity to care for children by:

- Providing mental health consultation to existing early child development, primary health care, school, recreation, and other community programs and organizations involved with the healthy development of children and families;

- Supporting and educating families and promoting the full participation of families in all aspects of planning for children's health, wellbeing and development;

- Working with community organizations and institutions to address the social determinants of health, build resiliency and reinforce protective factors, in order to be supportive of children and families experiencing mental illness;

- Providing increased collaboration and resources to facilitate Aboriginal communities in developing mental health programs based on their individual cultures and needs, as well as to ensure full access by Aboriginal children to culturally competent programs and services in the broad children's mental health system; and

- Reaching out to other cultural groups that under-utilize services.

Improving Performance

Accountability and outcome monitoring are key issues that need to be addressed across all systems and sectors serving the mental health and related needs of children. A new system is needed to coordinate services and oversee accountability for improved outcomes. As well, comprehensive information systems need to go beyond monitoring outputs (services provided) to also monitor broad outcomes across related sectors.

This plan will improve accountability and outcome monitoring by:

- Establishing a formal provincial children's mental health network that will facilitate more effective planning and service coordination across all related sectors including public health and primary care, early child development, schools, community living, child protection, addictions, youth forensics and youth justice, adult mental health, hospitals, and crisis and residential services; and

- Establishing a comprehensive provincial children's mental health information system that can be used to monitor outcomes and evaluate activities in all related programs and sectors, and that can be linked with larger databases in health and education.

Meeting the challenges

Children's mental health programs and services are intended to reduce the impairments associated with mental illness, optimize development and wellbeing for children, and ensure the effective and efficient use of public funds towards these ends. This plan addresses these outcomes. It uses a staged approach over the next five years to improve treatment and support for children with serious mental illness, reduce risks, and increase the capacity of families and communities to ensure wellbeing and healthy development for all children. While additional resources will be required, significant savings are also expected over the life of the plan through the increased efficiencies that will result from improved performance by placing an emphasis on accessible community- based services, improved collaboration and coordination, better performance management, and the use of evidence-based practices.

In the long term, treating mental illness in children, reducing risk, and supporting the contribution families and communities make to the mental health of children will help all of us to avoid the much greater "downstream" costs resulting from the prevalence of mental illness in children.

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CHAPTER 1

INTRODUCTION

Research shows that the average overall community prevalence rate for mental disorders in children and youth is 15% (see Appendix A). This means that in BC, approximately 140,000 children and youth experience mental disorders causing significant distress and impairing their functioning at home, at school, with peers, or in the community.

Reports from many jurisdictions indicate that the burden of suffering imposed by children's mental health problems and disorders is not diminishing. When present, they permeate every aspect of development and functioning, including family relationships, school performance and peer relationships (US DHHS, 1999; National Institute of Mental Health [NIMH], 2001; Offord, et al, 1989). Often the most serious of these illnesses continue into adulthood and affect productivity and functioning in the community, particularly if they are not detected early and treated effectively. No other illnesses affect so many children in such a serious and widespread manner.

We need to make better progress in reducing the individual, family and societal burden of suffering resulting from children's mental illness. The mental health problems of children have been recognized as a significant public health issue both internationally and by other Canadian provinces (US DHHS, 1999; NIMH, 2001, Health and Welfare Canada, 1991). In BC, many factors have helped create the momentum to address these problems by developing a mental health plan for children and youth. The appointment of the Minister of State for Mental Health in June 2001 signaled government's commitment to better address mental health issues. In August 2001 the Deputy Minister to the Premier requested that the Ministry of Health Services (MOHS) and the Ministry of Children and Family Development (MCFD) undertake joint planning for children's mental health. An External Advisory Committee for Child and Youth Mental Health was also established, with a mandate to monitor and advise on the province's progress towards resolution of identified children's mental health issues, including the development of this Children's Mental Health Plan (the Plan). The External Advisory Committee reports to the Minister of State for Mental Health.

This Plan distills the knowledge of those involved in the mental health system and draws upon the experience of other jurisdictions as well as on a province-wide consultation (the Consultation), conducted in 2000, that included the perspectives of children and their families, service providers and service partners (see Appendix B). The Plan is also informed by an extensive review of current research literature on effective practices in children's mental health (see Appendix A). Additionally, the Plan rests on the work of the Joint Working Group established by MCFD and MOHS to improve transitions for children with mental illnesses, both as they move into the adult mental health system and as they

move between hospital and community mental health services (see Appendix C). The Plan outlines the primary challenges to be addressed, describes a framework and required service delivery changes, and provides an associated implementation plan. It broadens the accountability for children's mental health to many government and community stakeholders and forms the foundation for investment priorities and business planning to optimize the mental health of children.

The following definitions are used in this document:

"Children" refers to all those under the age of nineteen years. While recognizing the importance of and distinctions among all ages of young people, including infants, children and adolescents, we have chosen to use "children" as the generic term for the sake of brevity.

"Mental health" includes all aspects of human development and well being that affect emotions, learning and behaviour.

"Mental health problem" is used to describe any emotional or behavioural condition that may cause significant distress and impair functioning, but not to a degree that meets diagnostic criteria for a mental disorder.

"Mental illness" and "mental disorder" are used interchangeably to mean any emotional, behavioural, or brain-related condition that causes significant impairment in functioning as defined in standard diagnostic protocols such as the American Psychiatric Association's Diagnostic and Statistical Manual (DSM) (APA, 2000).

"Child and Youth Mental Health Services (CYMHS)" refers to the community mental health services for children that are funded by MCFD, including staff designated as mental health clinicians and contracted agency staff, and, funded by MOHS, sessional physicians (who may be psychiatrists, pediatricians or family practitioners).

"Formal children's mental health system" refers to a range of institutional and community mental health services for children. They include CYMHS as defined above; the Maples Adolescent Treatment Centre; Youth Forensic Psychiatric Services; and, through MOHS and Health Authorities, psychiatrists, pediatricians and family physicians providing mental health care to children; and acute care providing specialized mental health services to children through emergency rooms, crisis response units, psychiatric and pediatric mental illness hospital admissions.

"Broad children's mental health system" refers to the wider range of mental health-related services that are funded by MCFD, MOHS, the Ministry of Community, Aboriginal and Women's Services and the Ministry of Education (MOE), including primary care; counselling and psychological services in schools; services purchased for children-in-care who have mental health problems or illnesses (e.g., assessment, treatment, respite, residential care); family services; public health nursing services; parenting courses; early childhood development; addiction services and a range of other services provided to support children and their families.

"Multi-Disciplinary Team" refers to a group of people who come from several disciplines. In the case of mental health, those most frequently included are clinical social workers, psychiatric nurses, psychiatrists and psychologists, though occupational therapists, art therapists, child and youth care workers and members of other disciplines may be included. A multi-disciplinary team needs to be distinguished from a multi-sectoral team, as described below.

"Multi-Sectoral Team" refers to a team of workers who come from different services sectors, such as acute care, addictions, advocacy groups, child protection, consumers, corrections, education, guardianship, mental health, police, public health and others. A multi-sectoral team may be multi-disciplinary, but could in fact be composed of members of only one discipline, e.g., social work.

CHAPTER 2

BACKGROUND

2.1 Prevalence of Children's Mental Disorders

There is a large burden of suffering associated with children's mental disorders, particularly when problems are severe and impair functioning at home, at school with peers and in the community. The following table (adapted from Appendix A) gives estimates for the number of children in BC who may be affected by mental disorders.

TABLE 1. Prevalence of Mental Disorders in Children and Youth

Disorder	*Prevalence (%)*	*Approximate Number in BC* [1]
Any anxiety disorder	6.5	60,900
Conduct disorder	3.3	30,900
Attention-deficit/hyperactivity disorder	3.3	30,900
Any depressive disorder	2.1	19,700
Substance abuse	0.8	7,500
Pervasive developmental disorder	0.3	2,800
Obsessive-compulsive disorder	0.2	1,900
Schizophrenia	0.1	900
Tourette's disorder	0.1	900
Any eating disorder	0.1	900
Bipolar disorder	< 0.1	< 900
Any disorder	15	140,500

[1] *The approximate number who may be affected is based on a population estimate of 936,500 children and youth in BC*

In addition to the large numbers of children and families affected, the burden of suffering is worsened by the fact that in BC, as in many jurisdictions, the majority of children with mental disorders are not being identified or offered effective treatments (Offord, et al, 1989; US DHHS, 1999).

2.2 Adequacy of Children's Mental Health Services

There is general agreement that current treatment services for children with mental health disorders and problems are inadequate.

> "It is crucial that mental health funding not be cut in future, but in fact be increased." (p. 23, Children's Commission, 2002)

The prevalence of children's mental illness far outpaces clinical treatment capacity in most jurisdictions, with the result that there is substantial unmet need for services. The Ontario Child Health Study (Offord, et al, 1989) determined that only one in six children and adolescents with a mental illness received some form of specialty mental health service. The US Surgeon General's report on mental health estimated more recently that 70% of children and youth with mental illnesses were not being adequately treated (US DHHS, 1999).

The struggle to provide adequate and well-coordinated services for children and youth with mental health issues is not a new one, nor is it unique to BC. For instance, in 1990, "Foundations for the Future," a report of Health Canada's Federal/Provincial/Territorial Working Group on Child and Youth Mental Health Services, commented:

> "Historically, mental health policies and programs have largely focused on the treatment of the adult population; consequently, services for the young have developed slowly and as an adjunct to programs for adults." (Health and Welfare Canada, 1991, p.1)

This report identified three priority issues:

- Planning and coordination of a broad children's services network,
- Integration of hospital and community mental health systems, and
- Preventive and early intervention services.

A second report of the Working Group, "Building for the Future" (Health and Welfare Canada, 1993), suggested a series of goals and initiatives to address the issues, consistent with the approaches that are suggested in this Plan.

The United States Surgeon General arrived at more detailed conclusions pertinent to children's mental health. These conclusions included the following:

- Mental illnesses and mental health problems appear in families of all social classes and backgrounds, though cultural differences exacerbate the general problems of access to appropriate mental health services.

- Those children who are at greatest risk may also experience physical problems, intellectual disabilities, low birth weight, family history of mental and addictive disorders, multigenerational poverty, and caregiver separation or abuse and neglect.

- Families have become essential partners in the delivery of mental health services for children, making it critical to assess the mental health of children in the context of familial, social and cultural expectations about age-appropriate thoughts, emotions and behaviour.

- Primary care and the schools are major settings for earlier recognition of mental illness in children, yet staff trained to identify the disorders are limited, as are options for referral to specialty care.

- The multiple problems associated with serious emotional disturbance in children are best addressed with a systems approach in which multiple service sectors work in an organized, collaborative way.

- Preventive interventions have been shown to be effective in reducing the impact of risk factors for mental illness and improving development, and a range of efficacious treatments exists (US DHHS, 1999).

2.3 The Child and Youth Mental Health System in MCFD

Currently mental health services for children with mental disorders and their families provided by MCFD are delivered by three programs within the Ministry: Maples Adolescent Treatment Center (the Maples), Youth Forensic Psychiatric Services (YFPS), and Child and Youth Mental Health Services (CYMHS).

The Maples, with an annual budget of $12.5 million, is a designated provincial mental health facility under the Mental Health Act. Services include short-term inpatient or outpatient multi-disciplinary assessments, care planning, intervention and ongoing outreach, consultation and respite support. The target population consists of significantly psychiatrically and behaviorally troubled young people aged 12 -17, as well as those found not criminally responsible due to a mental illness and those found unfit to stand trial.

YFPS, with an annual budget of $13.1 million, provides assessment and treatment services for young offenders in the community and in custody, through clinics and contracted service providers throughout the province, and in addition has an inpatient assessment unit for youth remanded for a court-ordered assessment.

CYMHS, with an annual budget of $43 million, provides a wide range of community-based specialized mental health services to mentally ill children and their families. Two complementary child and youth mental health service components have been established. First, a network of MCFD mental health staff and sessional psychiatrists function on specialized teams or in integrated child and family centres. Consistent with a multi-disciplinary approach to service provision, MCFD program staff typically include psychologists, social workers, counselors with graduate degrees, and nurses. Contracted agency equivalents to MCFD staffed services operate in Powell River, Prince George and Vancouver/Richmond.

Second, an extensive program of 170 contracted service agencies extends the MCFD staffed programs by providing specialized and mental health-related

community-based services. While these services are funded directly by MCFD, they can be funded jointly with other ministries, and non-government sources, to achieve a desired level of service integration in communities. They are designed to complement or augment staffed services, and offer a flexible way of responding to varying regional needs.

Within MCFD staffed services and contracted agency equivalents there are two major categories of service as follows:

Direct Clinical Services are provided to a specific, identifiable and registered client or to others involved in direct support of this client. These services include intake, screening and referral, assessment and planning, treatment, case management, and clinical consultation. Cases are prioritized according to risk and impairment, with individuals who are suicidal or experiencing extreme impaired functioning due to acute mental illness having highest priority.

Targeted Community Development is comprised of a range of services intended to support other service providers (e.g., school counselors, family physicians) who may be working directly with individuals not registered with CYMHS or contracted agency equivalent programs and other community services and programs. Targeted Community Development may include mental health consultation, program consultation, service system planning, community coordination, and education and health promotion, all targeted to children's mental health needs. Currently, most CYMHS staff are unable to provide these services due to the over-riding demands of Direct Clinical Services.

2.4 Child and Youth Mental Health Services in MOHS

MOHS, through the Medical Service Plan and health authorities, is responsible for medical services, community-based adult mental health programs, and all acute care psychiatric programs including hospital services for children.

Acute care, as one component of a continuum of services for children's mental health, provides the following:

- Emergency services for children experiencing psychiatric crisis, and
- 101 specialized inpatient hospital beds for children with mental disorders requiring stabilization and/or intensive assessment and treatment.

2.5 Gaps in the Current Service Delivery System

It has been recognized for some time that the child and youth mental health system faces many challenges. In the summer of 2000, the province undertook a Consultation (Appendix B) to identify these challenges and begin to plan to remedy the issues. The Consultation included youth, families, service providers and other partners in the delivery of mental health services to children and youth. In addition, in 2001/2002, MCFD contracted with MHECCU to conduct a review of evidence-based practice with the overall goal of improving mental health outcomes for children and youth (Appendix A). Throughout the following sections, the Plan has drawn on the research foundations established in the research review. The following common themes and gaps in services have been identified through the review as well as through the Consultation.

- Need to make infrastructure changes to support the implementation of improvements within the current child and youth mental health system, facilitation of collaborative partnerships, and support for a consistent approach to the delivery of mental health services regardless of location:
  - development of clinical policies and procedures (underway);
  - development of best practice standards and guidelines;
  - improved information management system and data collection;
  - standardized intake, screening and outcome measures, and
  - standardized recruitment strategies and job descriptions.

- Need to improve partnerships with Ministry of Health Planning (MOHP), MOHS, health authorities, MOE, school districts, physicians, teachers and other system partners:
  - transitional services for youth aged 15-24;
  - linkages between community and acute care services;
  - suicide prevention and intervention services;
  - concurrent addiction and mental disorders;
  - school-based mental health services;
  - early identification and intervention for children and youth experiencing or at risk of developing a serious mental illness; and
  - improved services for children under 12 years.

- Need to establish specialized MCFD mental health residential resources for mentally ill children, within the current allocation for child protection, without the need to bring children into care.

- Need to improve coordination within MCFD services for children with complex and concurrent disorder issues (e.g., developmental delays in mentally ill children).

- Need to enhance quantity and range of services to address long waitlists.
- Need to provide services at more flexible times and in locations more convenient for children and families (e.g., home, school, physicians' offices).
- Need to provide additional supports (e.g., respite and other family support services) to families whose children have mental health needs.
- In partnership with Aboriginal communities, need to develop appropriate services for Aboriginal children and their families.
- Need to develop appropriate services for children and their families who belong to the diverse ethno-cultural groups that are a part of BC.
- Need to provide education for the general public, including children and youth, to increase awareness of mental health and mental illness, in order to reduce associated stigma.
- Need to target culturally appropriate information to children with a mental disorder and their families to provide education about mental disorders, their treatment and available services.
- Need to provide specialized professional education for mental health clinicians and other service providers (e.g., physicians, school counsellors and teachers, addictions counsellors).
- Need to support consumer, advocacy, and self-help and mutual aid groups for children with mental illness and their families.

It is the intent of this Plan to address the gaps described above over a five-year implementation period.

CHAPTER 3

VISION AND FRAMEWORK

This Plan for addressing the mental health needs of children is built on the following vision and framework, as adapted from the Alberta Child & Youth Initiative Policy Framework (2001).

3.1 Vision

> Mentally healthy children and responsible families
> living in safe, caring and inclusive communities.

The vision is supported by the following considerations:

- Children are society's foundation for the future; therefore, they must be primary beneficiaries of society's resources.
- The family is central to the provision of care for their children.
- Children and their families have strengths and potential.
- The determinants of health influence the development of children, families and communities.
- Individuals, families, communities and governments share responsibility and accountability for achieving optimal mental health.
- Mental health is more than the absence of mental illness or freedom from psychiatric symptoms.
- Children have unique mental health needs that are different from those of adults.
- Some children are seriously impaired by mental health problems and illnesses.
- The severity and duration of mental illnesses can be reduced through prevention, early identification and intervention, thereby reducing personal and societal costs.
- Children who are mentally ill and their families should have access to timely, effective and culturally appropriate treatment and support.

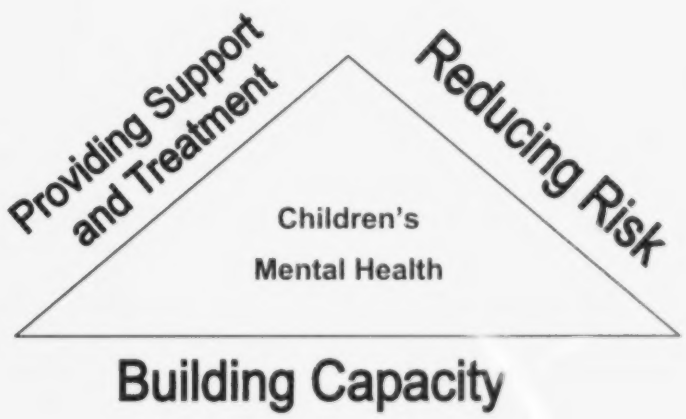
3.2 Framework

The severity, duration and relatively high prevalence of mental disorders in children require that we take action to reduce the burden of suffering in BC.

Children's mental illness needs to be addressed not only because children are important in their own right, but also because the mental health of the entire population has a long term impact on the province's workforce, productivity and long-term competitiveness.

A review of the literature and developments in other jurisdictions indicates that the most promising children's mental health service strategies should utilize a multi-faceted approach using both population and individual intervention strategies. Interventions should occur at the following three conceptually distinct but interrelated levels in order to maximize the impact of scarce resources. First, treatment services should emphasize early recognition and timely and effective intervention built on evidence-based practice. Second, it is important to foster resilience in children and reduce their risk factors. Finally, consistent with recent strategic shifts at MCFD (Appendix D), it is important to build the capacity of children, families and communities to optimize the mental health of children.

BC's approach to children's mental health is therefore composed of the following three key components:



By intervening in these three areas we will focus specialized children's mental health clinical services for those mentally ill children most in need. Second, we will identify those children at risk for developing mental problems and illnesses and intervene early to prevent or mitigate problems. Third, we can work with families and communities to build capacity to support the healthy development of children and families.

Providing Treatment and Support

Mental illness in children is a reality. The most commonly occurring mental disorders in children are anxiety disorders, attention deficit/hyperactivity disorders, conduct disorders, substance abuse, and depressive disorders, many co-occurring, accounting for approximately 90% of children's mental disorders (see Table 1 on p. 5). Other less frequently occurring disorders (e.g., psychosis and bipolar disorders) carry a tremendous personal and community burden. For those children who develop a mental disorder, a range of evidence-based approaches, programs and services are needed. Research tells us that services are most effective when they can be provided in the child's home community, and when a multi-disciplinary approach is used. Consequently, our efforts should focus on recruiting and retaining staff from a variety of professions distributed widely across the province and supported by specialized expertise when necessary.

> Jennifer is a 15-year-old girl who has always been described as sensitive and shy. Since entering high school she has found it increasingly difficult to attend, and frequently stays home with complaints of headaches or stomachs. Her physician has failed to find any medical cause for her illness. Jennifer's mother describes her as a 'constant worrier' and is concerned that her grades are falling and she doesn't have any friends.

Treatment and support also need to be responsive. When services can be provided as soon as the need is identified, the impact on children, families and communities can be minimized. Otherwise, problems escalate. Children who do not receive treatment and supports when they are needed can end up in hospital or foster care, or in worse situations on the street, in jail, addicted to substances or committing suicide.

Reducing Risk

Reducing risk means preventing problems before they occur, or mitigating their impact when they do occur, in children who are at increased risk. Risk factors may include individual characteristics (such as difficult temperament, learning disabilities, biological injury or genetic factors), or environmental factors (such as poor housing; parental problems, including substance abuse; or poverty). Reducing risk can also refer to strengthening protective factors--those factors that help lessen the impact of risk factors in children and their families.

Resilience, or the ability to withstand adversity, is thought to occur as a result of certain protective factors being present. Several protective factors have been associated with resilience, including long-term supports from at least one consistent care-giving adult, good learning abilities, good social skills, an easy temperament, few siblings, a sense of skill or competency, and positive beliefs about the larger world.

A mental health clinician and a school counsellor collaborated to develop a course on depression management. High school students who are at risk for depression can take the course for credit. They are working to make the course available across the school district.

Some children, because of inherent vulnerabilities, are always at some degree of risk for developing a mental illness. In addition, some families are disadvantaged, or encounter periods of significant stress, and will require additional support to nurture their children. Timely and easy access to a variety of family development and support programs (e.g., parent-teen mediation, parenting groups) will assist parents in developing knowledge, skills and abilities that will help them to care for and support their children when they are at risk. As well, some children can benefit directly from programs that help them to understand and manage their particular risk conditions (e.g., anger management groups, social skills groups).

Providing information, support and consultation to service providers who work with broad populations of children will assist in early identification of emerging mental disorders. Early intervention initiatives will be key in mitigating the potentially disabling effects of mental illness in children.

Building Capacity

Promoting the capacity of families and communities to support the mental health of children is the third key component of this Plan. Families can significantly influence their children's development, including their mental health. While most families at most times have no difficulty in providing nurture and support for their children, families develop by acquiring new skills and understanding in order to optimize their own children's growth and contribute to the healthy development of other children in their community. Families are usually the first to recognize the early onset of mental illness. Support and development of family capacity is critical, as the effective treatment of a child's mental illness is often dependent upon the participation of the family in the treatment process.

Mental health clinicians, community agencies and consumer advocacy groups have worked together to develop a manual to guide communities in delivering a day-long collaborative workshop, "Supporting Families with Parental Mental Illness."

Community capacity development is also critical. Children's environments can have a significant influence on their development and mental health. The ability to overcome a serious mental illness can be

influenced by the support received from significant others in their community. *School, peer relations, and community activities* are critical factors in a child's life. It is therefore important that attention be directed towards reinforcing positive community factors, and overcoming destructive influences.

Concerned about the paucity of services for children and families, a group of service providers (E Fry society, MCFD mental health and child protection, RCMP, schools, church ministers, senior's groups, service clubs, Chamber of Commerce, Community Futures, Village administration, Band administration) met to talk about the concerns and the resources the community had. The group has begun initiatives on bringing the Cadet Corps to the community, creating a mentoring program for youth, and a proposal for a school based family service team.

By working in collaboration with organizations and institutions in the community that routinely interact with and influence children, the mental health system's capacity to intervene early and help children overcome or avoid a serious mental illness is significantly strengthened. For example, partnerships with schools such as the Australian "Friends Project" or the Vancouver based "Primary Prevention Project for Anxiety Disorders" have demonstrated that through teachers the school can be supported to prevent mental illness and help identify children in need of treatment.

The growing body of knowledge related to the determinants of health indicates that mental health is influenced by early child development, especially in the very early years when the child's brain is undergoing significant development. Reinforcing and supporting efforts to achieve healthy early child development is therefore another important strategy for improving mental health capacity. Mental health clinicians contribute to community capacity building initiatives by providing advice about normal and challenged child growth and development to their more involved service partners. In this way, programs are planned and implemented to best suit the needs of children, and the capacity of the community is enhanced both by the programs provided and by the learning that occurs as a result of participation of children's mental health specialists.

Two mental health clinicians consulted to an integrated day care on their "Parent and Child" days. One clinician assisted the teachers with the parent education group while the other observed the children's playgroup and helped to plan learning strategies.

CHAPTER 4
BLUEPRINT FOR CHANGE

The Plan for improving children's mental health in BC is based on the three key components of the Framework as well as a fourth component designed to achieve performance improvements:

- **Providing Treatment and Support**: providing a continuum of services for mentally ill children, their families and other caregivers and service providers so that the children can achieve optimal functioning;
- **Reducing Risk**: applying the principles of prevention, early identification and intervention, risk reduction, risk and protective factors and resilience to assist community and service partners to lessen the likelihood of mental illness in children and, when it occurs, to alleviate its effects;
- **Building Capacity**: working in partnership with families, communities, and the many child- and family-serving organizations throughout BC to improve the mental health of children; and
- **Improving Performance**: implementing needed infrastructure supports that will improve performance and make implementation of the Plan possible.

4.1 Providing Treatment and Support

Providing treatment and support for mentally ill children and their families is an essential component of a framework for children's mental health. It is in this aspect of the framework that the activities of the formal children's mental health system are most visible. The following changes are needed:

4.1.1 Provide a basic level and range of core services in every region.

An adequate children's mental health system ensures the accessibility of appropriate children's mental health services when and where they are needed. During the Consultation (Appendix B), families and frontline professionals repeatedly told us that children's mental health services were not easy to find in the community. They also said that often when they did find the services, there were long waiting lists. Service capacity must be increased to provide a basic level of accessible services. When appropriate, services should be delivered in places where children and their families spend their time (e.g., schools and homes), at flexible times (e.g., evenings and weekends), and they should be easy to find. Culturally appropriate approaches also need to be developed.

A basic range of specialized children's mental health services available in each region should consist of the following as a minimum:

- **Consultation** – Two types of consultation may occur. "Clinical consultation" centers on a child who has been assessed and may be receiving mental health treatment. It is provided to those individuals involved with the child, including, for example, parents, teachers, child protection workers and family physicians. "Mental health consultation" is provided to service providers in the community and is not client-specific, but rather related to more general clinical considerations. Since the mental health clinician has not assessed the child, comments and advice can only be provided about children in general who have certain kinds of behaviors that may be causing concern (e.g., anxious behaviors, suicidal ideation, disordered eating).

- **Community-based assessment, counselling, and therapy services** – Counselling and therapy are outpatient interventions based on broad and specialized assessments that involve working directly with the child and/or family to reduce the impact of mental illness and improve overall functioning. Research tells us that generally, psychosocial treatment produces measurable positive outcomes compared with no treatment. Research also indicates that some specific forms of therapy are most effective for specific mental illnesses. These therapies are sometimes delivered in an individual format, sometimes with families and sometimes with groups.

- **Home-based and outreach services** – Services are provided on an outreach basis to children and families in their homes and in school settings. These services tend to have a family focus, and offer advantages of delivering services within the natural setting of the child and family, thereby normalizing as much as possible the impact of the mental illness.

- **Family development services** – Family development services are a critical component of service delivery and assist families in responding appropriately to their child's mental illness and in understanding its nature, treatment and prognosis. These services, including parent education and support groups, will help parents learn methods for managing and assisting their child, using techniques such as behaviour modification, problem solving, and conflict resolution. Respite, also a family support service, allows the caregiver a brief opportunity to recover from some of the stress associated with caring for a child with a mental illness.

- **Day treatment** – These services augment the basic educational program for students who have personal, social and special educational needs. Day treatment programs often offer an integrated set of educational, counselling and family interventions that may involve a child for three to five hours a day.

- **Crisis intervention and stabilization** - Services focus on crisis intervention, prevention and management, provided in a person's home, another location, or by telephone. Typical services include crisis telephone counselling, immediate face-to-face interventions, and other emergency outpatient services.

- **Residential services such as therapeutic family care, crisis stabilization and supported independent living** – Therapeutic family care provides a home and a management program for children and youth when they are unable to live in their own home due to severe mental illness. Crisis stabilization requires only a brief stay away from home to relieve a crisis. Supported independent living provides funding and supports for older youth to be able to live on their own.

- **Acute Care** – Hospitals provide inpatient assessment and treatment on a short-term basis for children with complex mental illnesses who require medically-related treatment or a comprehensive evaluation not available on an outpatient basis.

The continuum starts with the least intrusive services and ends with the most intrusive. Research tells us that not only are less intrusive approaches (as described in the first part of the continuum) less expensive, but they are also more effective and meet the needs of greater numbers of children. Consequently, the continuum should focus on the less intrusive approaches, thereby limiting a seemingly endless requirement for additional funding for expensive clinical services.

Service models for rural areas of the province will differ substantially from more urban areas. Rural areas typically have fewer highly trained children's mental health professionals and less access to bed-based care, at least in their own communities. They can provide better community care if more back-up is made available to them on a consultation basis and through outreach from urban-based mental health specialists. The use of telehealth technology can also increase the ability to provide necessary assessment and treatment as close to the child's community as possible.

4.1.2 Work in partnership with other service sectors to address the mental health needs of children with complex multiple problems such as mental handicaps and mental disorder or addiction problems and mental disorder.

Some children with multiple problems require extra efforts to address their needs and to support their families and communities in caring for them. While these youngsters are not the sole responsibility of CYMHS, it is critical that we work

with the service sectors that share the responsibility for planning and providing the services they require.

4.1.3 Improve collaboration with general practitioners and family physicians.

Frequently general practitioners and family physicians are the first point of contact for children with mental disorders and their families. These physicians have usually developed long-term relationships with the children and families and are aware of health and familial factors that might influence the child's treatment. As well, in smaller communities these physicians are the primary follow-up resource for any medical recommendations that may have been made by outreach psychiatrists.

We need to place more emphasis on supporting and more effectively integrating general practitioners and family physicians into the children's mental health service system. Physicians also need to be aware of local referral procedures and included in collaborative planning activities and training and education events.

4.1.4 Improve the coordination of transitions from the child to the adult mental health system, and between community and hospital.

One of the most glaring deficiencies in the current state of child and youth mental health services is the lack of service continuity in the transfer of care from children's mental health to adult mental health and between communities and hospitals. It is essential that planning for the transition from children's mental health to adult mental health should begin well ahead of the formal transfer at age 19. While children's stays in hospital should be brief and focused on crisis stabilization, it is critical that good communication exists between the hospital (whether through emergency, pediatric or psychiatric units) and community mental health in order to maintain continuity of treatment. Differences in rural and urban communities will need to be reflected in variations in planning and communication.

Formal protocols need to be developed and implemented and more effective communication links need to be established and maintained. Work has begun on this activity through a Joint Working Group (MCFD and MOHS) to address youth-adult and hospital-community transition issues (Appendix C). This work will support regions and communities in their protocol development. It will be important to capitalize on the momentum provided by the Plan, the work of the Joint Working Group, and the development of co-terminus MCFD regions and health authorities.

4.1.5 Improve equitable access to psychiatric acute care for children and youth-- locally, regionally and provincially.

There is pressure on the current capacity for inpatient psychiatric care for children and youth in BC. The Report of the Joint Working Group (see Appendix C) makes the following recommendations in this regard:

> Appendix 6, Recommendation 6: "That crisis stabilization and short-term assessment and treatment (STAT) residential/hospital care be considered as essential secondary level service, and as such regional authorities establish their availability on a regional or sub-regional basis." The report furthermore goes on to note that there are only 7 such STAT beds in the province at the time of the report.
>
> Appendix 6, Recommendation 8: "That the regional health authorities and regional hospitals with general medical pediatric care beds review the need for a response capacity for children and younger youth with acute psychiatric/emotional disorder."

The recommendations of the Joint Working Group need to be addressed collaboratively by MOHS and MCFD.

4.1.6 Maintain effective interventions supported by research evidence as the standard of practice throughout the service system.

The Mental Health Evaluation and Community Consultation Unit (MHECCU), of the Department of Psychiatry at the University of British Columbia, is undertaking a review of recent research into the effectiveness of various approaches to the assessment and treatment of children's mental disorders and problems. The first phase of the review has been completed. Draft interdisciplinary clinical practice parameters have been completed for five key mental disorders, selected according to their importance with respect to the burden of suffering associated with prevalence, severity, and costs (Appendix A). Because research results are constantly changing, these practice parameters are expected to be updated regularly to reflect new findings.

Draft guidelines have been completed on the following disorders:

- Attention-deficit / hyperactivity disorder
- Conduct disorder
- Depression
- Obsessive-compulsive disorder
- Schizophrenia

Over the next two years, draft guidelines will be completed on other anxiety and mood disorders, concurrent disorders (mental health and substance abuse), eating disorders, neuro-developmental disorders, emotional and behavioural problems, parenting problems and child maltreatment (the latter two as they relate to mental illness). Because some of the areas that will be investigated are areas where service partners have a significant role (e.g., learning disorders, autism, substance abuse, parenting problems and child maltreatment), it will be important to collaborate with them in the development of practice parameters for these areas.

We fully expect that the implementation of the practice parameters will result in a significant change in practice. The practice parameters will need to be integrated into practice through intensive initial and then on-going training, supervision, mentoring and performance monitoring. The parameters will also need to be communicated to mental health practitioners, appropriate governing bodies, and accreditation and regulatory agencies.

4.1.7 Review and revise existing standards and competencies to comply with evidence-based practice guidelines for all direct service mental health clinicians and provide ongoing training to maintain the standards.

Providing children's mental health services requires specialized education, knowledge, skills and experience. Some children's mental health clinicians are regulated by professional organizations or colleges, but others are not required to have such an affiliation. We will continue to work with regulatory bodies and professional associations to elicit their collaboration and support in attaining congruency between the competencies and professional standards. In addition, professional regulation of all mental health clinicians should be encouraged.

While standards and competencies currently exist, they require review and revision to ensure that they are consistent with evidence-based practice. Especially in the context of community governance, these standards and competencies will be essential in setting guidelines for practice in regions and communities. It will be important for the guidelines to be flexible enough to allow for differences between rural and urban communities while at the same time providing consistency in practice.

Recommended practices change as research provides us with new evidence regarding the best approaches to the variety of children's mental health problems and illnesses. A training plan will ensure that clinicians are kept informed of and skilled in evidence-based treatment approaches. In addition, training that crosses sectors will help to ensure that the various service providers in the broad children's mental health service system use collaborative and consistent approaches.

4.1.8 Institute appropriate clinical supervision mechanisms.

The Consultation that was conducted in 2000 (Appendix B) revealed that many MCFD community mental health clinicians are working without appropriate mental health supervision, particularly in more sparsely populated areas. It is imperative that appropriate clinical supervision by mental health-trained clinical leaders is provided for mental health clinicians throughout the province. Because mental health work includes consultation, education and community and family support activities as well as direct service, supervisors must have expertise in both clinical practice and community support services.

4.1.9 Maximize efficiency and effectiveness by standardizing practices that need to be consistent across the province.

Some ways in which we work with mentally ill children require a consistent approach across the province. The implementation of evidence-based practice parameters will not only result in more effective and efficient practice, but it will also introduce a degree of standardization in treatment approaches. We require greater consistency in such practices as intake and screening procedures; case prioritization; waitlist management; assessment; file management; information management; and information sharing and protection of privacy, including obtaining client consents and providing information to clients about their rights and responsibilities and our obligations in regard to their privacy. This consistency is critical in ensuring a high standard of service access and provision across the province.

4.2 Reducing Risk

With more than 140,000 children in BC challenged by mental disorders, it is necessary that the most promising and cost-effective service strategies be utilized. One way to decrease the gap between the service need and available resources is to reduce the risk or the impact of risk factors, thereby reducing the numbers of children requiring more expensive interventions. The following changes are needed.

4.2.1 Provide better information about mental health problems and illnesses for communities and the general public in order that people are better able to understand, identify and respond appropriately to children with mental illnesses.

There is considerable stigma and misunderstanding associated with mental illness. As a result, many treatable conditions are not recognized, children and

their families are reluctant to reach out for assistance, and some children with mental disorders experience significant discrimination, which may worsen their condition. When the impact of stigma keeps families from seeking assistance, children do not reach their full potential, more serious long-term impairment results, and sometimes these untreated mental illnesses lead to harm to self or others, or suicide. On the other hand, when parents, teachers, physicians and other community members recognize early indicators of risk for the development of mental illnesses and understand how to respond, the impact of the risk factors is minimized.

Educating children, families, and the community at large about children's mental problems and illnesses is an essential component of a risk reduction strategy. Educational strategies can include such things as a resource library (e.g., books and videos), pamphlets, websites, and speaking engagements, and can be developed in partnership with consumer and advocacy groups as well as community members who may have a special interest in mental health and mental illness.

4.2.2 Coordinate efforts to enhance protective factors, reduce risk, and intervene early in order to minimize suffering and cost resulting from mental illnesses and problems in children.

To provide the most effective and efficient risk reduction approaches, a coordinated and comprehensive approach is necessary. The concept of partnership implies that no one group, individual or agency need assume this role in isolation. Rather, the collaboration of multiple and diverse stakeholders, including families, expands the arenas in which risk reduction can occur.

The research evidence compiled by MHECCU should be used to guide continued attention to prevention and early intervention as a strategy to relieve potential mental illnesses and problems in children before they develop or become well established.

4.3 Building Capacity

In line with the six strategic shifts of MCFD (Appendix D), this Plan includes strategies to build community capacity in supporting children's mental health and in understanding and responding to children with mental problems or disorders. The following changes are needed.

4.3.1 Provide better information about mental health and mental illness for communities and the general public in order that people are better able to understand children with mental illness.

Just as educational approaches can reduce risk through better identification of mental illness, they can build capacity by improving people's understanding of mental illness and factors that contribute to mental health. The same strategies and partnerships that will be effective in risk reduction will be critical to building capacity.

4.3.2 Work in partnership with the broad range of child and family supporting organizations traditionally located outside of the formal mental health system.

The formal children's mental health system is composed of the services provided by MCFD, including staff designated as mental health clinicians and contracted agency staff; the Maples; YFPS and services funded by MOHS and regional health authorities, including sessional physicians; psychiatrists, pediatricians, general practitioners and family physicians providing mental health care in their private practice; and hospitals providing specialized mental health services to children through emergency rooms, crisis response, psychiatric and pediatric admissions (these include particularly British Columbia Women's and Children's Hospital, Queen Alexandra (Jack Ledger House), and Prince George and Surrey Memorial Hospitals).

While accurate data is not available, we estimate that the formal mental health system serves about 20,000 children annually. Considering that 15% (or more than 140,000 children in BC) have a mental disorder with extreme functional impairment at any given point in time, there is a substantial shortfall in the capacity of the formal mental health system to meet the needs of BC's most seriously mentally ill children. Further, in times of limited resources, it is not feasible to suggest a solution that would seek as much as seven times the current resource capacity. The formal system must therefore work in collaboration with the broader range of child and family support services located in such areas as: early child development, child welfare, and youth justice services in MCFD; primary care and hospital services, public health, adult mental health, and addiction services provided through MOHS and health authorities; the range of services provided through schools; the wide range of non-profit community-based service organizations located in communities throughout the province; and consumer and advocacy groups.

Working together more effectively is the key to expanding capacity to address the mental health needs of children in BC. Through meaningful collaboration and coordination, scarce resources can be efficiently deployed to enhance family and community capacity, reduce risks and build resilience in vulnerable children, and ensure that specific clinical consultation, case management and treatment resources are available to the most seriously mentally ill children and their families when the services are needed.

4.3.3 Fully involve families (and children when they are able) at all levels of planning and delivery of services.

Families are children's most important resource. Research is recognizing the importance of involving families in all aspects of mental health support. In the past, families have often been excluded and felt blamed for the mental health challenges facing their children. In an improved and more effective children's mental health service system in BC, families will be recognized and supported in the important contribution they make to enhancing capacity, reducing risk, creating resilience, identifying problems and assisting with treatment. Families will also be brought into the planning and evaluation of services so that their experience can be used to assure that appropriate outcomes are achieved. They are best equipped to describe what outcomes are the most useful to them and to contribute to the selection of evidence-based interventions that are most suited to achieving those outcomes. Families will be an especially valuable resource when they come from diverse ethno-cultural backgrounds.

4.3.4 Support Aboriginal mental health.

Children in Aboriginal communities in BC face unique mental health challenges. Aboriginal people have experienced considerable health, political and economic disadvantages associated with the arrival of non-aboriginal people. These disadvantages have affected the long-term ability of many families and communities to care for their children, with long-term impact on children's mental health and development.

Many Aboriginal children enjoy positive experiences and optimal development in healthy communities; however, some Aboriginal children experience risk factors that interfere with their development and functioning, and that can lead to mental health (as well as other) problems. These factors may include poverty (including inadequate housing, sanitation, water systems and nutrition); lack of access to health, social and educational programs and opportunities; exposure to racism; and the detrimental long-term inter-generational effects of residential schooling on families and communities. The presence of these factors place Aboriginal children and youth at increased risk for maltreatment, difficulties with school and learning, increased rates of suicide and substance abuse, and increased rates of involvement in the justice system compared to other children. Consequently, Aboriginal children are a priority in this Plan.

There are several challenges to overcome in order to improve mental health and developmental outcomes for Aboriginal children. Generally, health and social programs have not served Aboriginal children well. Aboriginal leaders and communities are best positioned to identify and develop better approaches, as

many have already done. Aboriginal communities, however, are not all alike. Needs and resources differ widely across BC. There are also important cultural differences among Aboriginal peoples. Consequently, more support needs to be provided to Aboriginal communities to develop their own approaches to children's mental health, in the manner and pace by which they want to proceed.

Another challenge involves the fact that many Aboriginal leaders question the emphasis that children's service systems tend to place on specialized individual (clinical) care, with a focus on "illness" or "crisis" management. Instead, these leaders argue, greater attention needs to be paid to community capacity building, including attention to the broader determinants of health and to preventing problems, or reducing risks earlier on. They suggest that factors necessary for healthy child and community development should be emphasized more. For example, early child development and family support programs, programs to enhance school and job opportunities for Aboriginal children (and their parents), and programs to involve elders in teaching traditional languages and activities, are suggested as ways to enhance school completion, and to prevent suicide and substance abuse.

Many Aboriginal communities are also challenged by remote geography, such that travel to specialized programs and services is expensive and arduous. As a result, unique approaches need to be developed together with Aboriginal communities to allow for thoughtful services suited to remote communities. Finally, it is a challenge to carefully coordinate services with other key providers such as Health Canada, which funds community health and other related programs for Aboriginal people.

4.4 Improving Performance

Formal performance management practices are essential in order to realize improvements in the effectiveness of services to children with mental disorders and their families and a consequent improvement in mental health outcomes. Consistent with government's commitment to improved accountability, the broad children's mental heath service system needs to adopt formal performance management practices at the provincial, regional and local level, focusing on outcomes and on engaging children, families and communities in the process. In this regard the following changes need to be made.

4.4.1 Establish a formal structure to better ensure coordinated planning and service delivery, across ministries and sectors, provincially, regionally, and locally.

A formal structure, or Children's Mental Health Network (the Network), is needed to ensure coordination at a provincial level. The Network will draw on members from the various jurisdictions that support children who are at risk of or

experiencing serious mental disorders and their families (see Appendix E). The Network will report to the Minister of Children and Family Development, the Minister of Health Services and the Minister of State for Mental Health, producing an annual public report on the province's progress toward implementation of this Plan. The function of the Children's Mental Health Network will be to improve the overall coordination and planning of services. The Network's primary focus will be to achieve effective collaboration and coordination of a range of seamless services so that the needs of mentally ill children and their families are paramount. Two examples of areas where the coordination and planning of this overarching Network are needed are in 1) services for children who have both a mental handicap and a mental disorder and in 2) equitably distributed and appropriate acute care facilities for children with mental disorders.

Joint Chairs of the Network (representing MCFD and MOHS) will be appointed by government and will rotate every two years. The Network will receive base funding and staffing support from MCFD and MOHS to support coordination of and planning for children's mental health services, training, education, research and evaluation.

Regions and communities also need to develop formal structures to support coordinated planning. Such structures already exist in some communities as Child and Youth Committees or other inter-agency committees. They will need to be developed in the other communities and in the regions. People with expertise in children's mental health have significant contributions to make in coordinated planning for children's services and should be members of such committees at both the regional and local levels.

4.4.2 Develop and implement an information technology plan to facilitate program planning, service coordination, quality assurance, research, collaborative networks and education.

One of the challenges in developing this plan has been the limited information available about children and the services we provide them, particularly for CYMHS contracted services, but also for MCFD services and MOHS services. The lack of current information has seriously curtailed our ability to identify outcome and performance targets as well as service capacity. Improvements in information technology offer great promise in responding to this critical need.

CYMHS is currently engaged in the development of an information technology plan, working with the Systems Services Branch of MCFD. The requirements for the information technology plan have been established so that new applications can be researched and precise funding estimates provided.

Information Management

An information management system will assist in program planning, service coordination, quality assurance, and research. Such a system needs to be available for use by both MCFD staff and contracted resources. It should provide client, service and service provider information, with appropriate protections for client privacy. It will need to have the capacity to link with other relevant databases (e.g., related acute care services).

Standardized Screening and Outcome-Based Follow-up

Currently our only measures of performance are output measures (e.g., number of children seen, number of groups provided), and these, while useful, do not describe whether or not improvements in outcomes are being achieved. Are children's lives improved through our interventions (e.g., improved family relations, moods stabilized, fewer school dropouts, fewer attempted suicides, fewer children in care)? Electronic applications are currently available that would enable mental health clinicians to use consistent intake, screening and follow-up approaches based on child functioning and outcomes. We would be able to collect the same information on all clients, make a consistent assessment of their current functioning, receive evidence-based treatment suggestions specific to the particular client, and follow up with the client during and after treatment and other interventions with measures of functioning and outcomes. Such an application will need to interface with the above-described information management system.

Distance Consultations (TeleHealth), Networking, Training, and Education

With the ability to deliver specialized expertise through TeleHealth technology, progress has been made in responding to the needs of rural communities, where large distances and limited resources make it necessary for most mental health clinicians to be generalists. We need to have this technology more consistently and formally available. Discussion boards and websites will assist in maintaining a network for children's mental health clinicians, who, because there are relatively few of them, frequently work in professional isolation. Innovations in training applications provide possibilities for more focused and less expensive training opportunities. This will be an area to explore with MCFD's Education Services Branch. Websites also present a significant opportunity to provide educational materials for clinicians, our professional colleagues and partners, children with mental problems and illnesses and their families, and the general public.

4.4.3 Develop an evaluation plan and collaborate with children's mental health researchers in a variety of settings.

In order to make the most of limited resources in a time of fiscal restraint, children's mental health interventions need to be both effective and efficient. The implementation of an information management system and an outcome-based intake, screening and follow-up tool, as described above, will enable us to evaluate our services as we have not been able to do in the past. In addition, in the creation of an evaluation plan, we need to include children, as they are able, and their families in the planning and the process.

The work being done at MHECCU on the current state of evidence-based practice indicates that there are significant gaps in the body of research literature. Additional research will increase our ability to be effective in our response to children's mental health problems and disorders. We can collaborate in the planning of and participate in research being done in post-secondary institutions and other settings as well as provide learning opportunities for research students.

CHAPTER 5

IMPLEMENTATION PLAN

5.1 Introduction

The improvement strategies described will be phased in over a five-year period. In the first phase (two years), it is recommended that initial efforts be directed primarily, though not totally, at improving performance. Many of the performance improvements are already in process. For instance, the current CYMHS clinical policies are being revised, and the Joint Working Group is addressing transitions from CYMHS to the adult mental health system and transitions for children between hospital and community mental health services. Other performance improvements can be implemented by re-focusing existing resources and aligning improvements in children's mental health with other restructuring initiatives across government (especially within MCFD, MOHS, and MOE). Phase 1 efforts will provide a solid foundation and the necessary service information for the development of detailed resource plans for the remaining years of the Plan.

Some early priorities will be as follows:

- begin immediate implementation of evidence-based practice in children's mental health,
- begin discussions with Aboriginal communities that will form the foundation for joint planning for mental health services for Aboriginal children with mental disorders,
- establish a Children's Mental Health Network,
- support regional planning that will integrate the recommendations of the Children's Mental Health Plan into the strategic shifts and related regional restructuring that are occurring in government over the next three years,
- begin to develop essential information management tools,
- begin to re-focus child protection, family development and residential services, and
- re-direct some Maples resources to evidence-based community services.

In subsequent years, the implementation focus will shift to strengthening and increasing the capacity of the children's mental health service system so that the gap between need and capacity is substantially reduced. The Plan will be

updated following the completion of Phase 1 in order that its outcomes inform the implementation of Phase 2.

5.2 Phase 1

5.2.1 Providing Treatment and Support

Evidence-Based Practice

In order to ensure accountability and the most efficient and effective use of limited resources, there is a need to better align programs and services with the best currently available research on evidence-based practice. In Phase 1 we will develop and provide ongoing training, supervision, mentoring and performance monitoring to encourage and reinforce evidence-based practices at all levels and in all sectors.

In partnership with MOHS and health authorities, training and education strategies will be coordinated with the implementation of the Plan, and will be facilitated through the Children's Mental Health Network. MCFD staff, contracted service providers, physicians, and other service system partners will be included in evidence-based practice education and training. Research will also guide the training and education efforts to be mindful of ethno-cultural differences and to include them in the curriculum.

Research indicates, however, that training and education strategies alone are not sufficient to implement or maintain changes in practice. Mental health clinicians must be supported and held accountable in their practice by appropriate clinical supervision and mentoring. This requires that regions ensure the availability of supervisors with expertise in children's mental health across the province. Different supervision models and approaches may be necessary to meet the differing needs of rural and urban communities. Our ability to implement performance monitoring of the implementation of evidence-based practice will also be vastly improved by the implementation of an information management system (see Section 5.2.4).

Community-Based Assessment, Counselling and Therapy

Funding will allow for mental health clinicians in local communities to provide assessment, counselling and therapy for children with mental disorders, thereby decreasing waiting lists and beginning to increase the numbers of children and their families who experience improved outcomes.

Residential Services

This re-focused funding will provide brief residential services for children with mental disorders where the primary need is treatment, not placement. These children have families who are generally able to care for them, but may be

exhausted or need a brief residential treatment intervention to develop new behavior patterns.

Many mentally ill children require brief periods of care outside their parents' home. In addition, many children who come into care have mental disorders. Both efficiency and improved service can be achieved by re-focusing existing Child and Family Development resources to provide specialized CYMHS residential services that will not require a child to be brought in to the care of the ministry in order to access needed services. In addition, child and youth mental health clinicians will be able to support these resources by providing training and consultation for their service providers. If the primary need for the family is to protect the child from harm, that family will still be served by child welfare services.

Maples

This funding will allow for the re-focusing of some existing resources from institutionally-based programs at the Maples to specialized community-based programs. One example might be the implementation of multi-systemic therapy.

5.2.2 Reducing Risk

Consultation

These funds will be used for mental health clinicians who will provide clinical and mental health consultation to service partners (including, for example, physicians, teachers, early child development workers, public health nurses--the people who are often in the closest contact with children who may be at risk or showing signs of mental illness), communities and ethno-cultural, consumer and advocacy groups. The intent of the consultations will be to enable mental health clinicians to use their specialized knowledge about mental health and mental illness to assist their partners in program development and delivery in ways that will reduce the likelihood or impact of mental illness in individuals and groups who are thought to be at risk, and to enhance the capacity of our community partners to recognize and respond to early signs of mental disorder, thereby reducing risk.

To address teen pregnancy a local Teen Clinic provides four hours of drop in service twice monthly at the local high school. The participants in the clinic consist of a physician, a public health nurse, a federal health nurse, a CYMHS clinician and a drug and alcohol counselor. The Clinic allows youth to access help anonymously, confidentially and in their own environment, with very little attrition. The team is working on a health talk show to be broadcast on the high school's radio station next school year.

Early Identification

To be developed in partnership with MOHS and health authorities, these funds will provide for a mental health liaison function--to develop and maintain working relationships with the partner sectors and to facilitate seamless connections between systems. These connections will also enable communities to work collaboratively to coordinate and enhance the broad children's mental health system to reduce risk. It is particularly important that connections occur with acute care, adult mental health, physicians, public health and school districts. In some regions connections also need to be developed with, for example, police, recreation, and other MCFD sectors such as child welfare.

These funds will also support the development and delivery of educational and training materials to support the early identification of children who have or are at risk of developing mental disorders. Some of the materials will be targeted for and to the diverse ethno-cultural groups who reside in BC.

Early Intervention

We not only need to identify children at risk at early stages, but we also need to be able to intervene early. In the context of children's mental health, early intervention has two meanings: we need to intervene early in children's lives (e.g., with infants, toddlers and pre-schoolers) and we need to intervene early in the course of a mental illness (e.g., at the first signs of psychosis or depression). These funds will provide some capacity for CYMHS to be able to respond to the needs of younger children, whose mental illnesses are often discounted as "a stage" or ignored simply because the children are too young to voice their problems. Additionally, these funds will support early evidence-based intervention in the onset of mental illness. An example of the latter might be in the onset of psychosis (see Appendix F). Interventions may take the form of clinical consultation to parents and partners, facilitation of transition between systems, and direct treatment. In both cases, attention will be given to varying ethno-cultural needs and the different needs of rural and urban communities.

5.2.3 Building Capacity

Building Partnerships

In one community, the fire chief was a member of a child and youth inter-agency planning committee. He had a particular interest and expertise in juvenile fire setting.

While specific funds have not been assigned to building partnerships, it is a critical element of success in the implementation of this Plan. The partnerships that have already been established and the new ones that will be developed, especially at regional and local levels, are the foundation of consistent, seamless services for children with mental disorders and their families. The broad children's mental health system (mental health-related services that are

funded by MCFD, MOHS, the Ministry of Community, Aboriginal and Women's Services and the Ministry of Education (MOE), including primary care; counselling and psychological services in schools; services purchased for children-in-care who have mental health problems or illnesses (e.g., assessment, treatment, respite, residential care); family services; public health nursing services; parenting courses; early childhood development; addiction services and a range of other services provided to support children and their families) forms a basis for the partnerships.

Mental Health Consultation

> To meet the need for service for children with severe behavior problems in schools, a CYMHS clinician proposed co-facilitating social skills training groups in the school with two resource teachers. Four hours of service per week in the schools served 19 children and youth. Close collaboration with the school personnel allowed for early intervention in developing crises, and the opportunity to educate around mental health issues. The resource teachers are hoping to facilitate the groups solo next year with the clinician available for consultation.

The role of mental health clinicians funded to provide mental health consultation to reduce the risk and impact of mental illness for children and their families will also include similar targeted consultation that is intended to build community capacity. Among both the general public that has frequent contact with children and the broad children's mental health system, there are tremendous gaps of knowledge, understanding, skills and experience regarding mental illness in children, and the needs and struggles of their families. The purpose of these consultations will be to build capacity so that people are better able to respond to the needs of mentally ill children and their families.

Resource Library

Community-based resource libraries containing books and videos related to children's mental illness will be developed and maintained in each region to support capacity building among mentally ill children and their families, communities, service partners and children's mental health clinicians. Regions will need to consider how best to provide resources for rural areas where people may find it difficult to access library materials that are centrally located.

In addition there are numerous excellent resources now available through a variety of web-sites. A part of the activities associated with the resource library will be to research those websites and ensure that information about them is widely available.

Family Development

This aspect of the initiative will use re-focused funds to provide a variety of supports for the parents and families of mentally ill children. For example, children and their families need to understand the specific mental illness they are experiencing so that they will be better able to manage the illness and prevent further ramifications. This funding will provide for supports such as parent and

child support and education groups and respite for parents when they need a break from caring for a child with extreme difficulties. Another area of focus for these family development services is in the support of consumer, advocacy, peer support and self-help groups.

Aboriginal Development

Children in Aboriginal communities in BC face unique mental health challenges. To respond to these challenges, over the next two to five years MCFD will fully involve Aboriginal leaders (ensuring a diverse array of representative input) in all aspects of the development of children's mental health programs and services, including the information systems needed to monitor outcomes. The need for increased resources will be more precisely delineated with input from Aboriginal leaders during Phase 1. The intent is to be flexible and to build greater capacity and support for Aboriginal leaders and communities to manage their own children's mental health programs and approaches, at the pace and in the ways that they see as most helpful. It is expected that different communities will take different approaches. Regardless of approach, while the main focus here is community capacity building, all Aboriginal communities will be fully supported to have access to the full range of existing programs and services that are available to all children in BC, including risk reduction and specialized clinical services as needed.

5.2.4 Improving Performance

Children's Mental Health Network

A formalized planning and coordinating capacity for children's mental health is central to implementing the strategy and recommendations reflected within this Plan. A Children's Mental Health Network (the Network) will be developed to ensure broad-based planning and coordination of services for children who are at risk of or are experiencing a mental illness and their families. Resources are required to establish and support the Network in partnership with resources from MOHS and health authorities. Funding will provide for secretariat, research and communication support.

Regional Planning

Concurrent with and supporting the transition to community governance, funding for each region to undertake the informed development of a Regional Child and Youth Mental Health Plan, built on evidence-based practice, is the second component of strengthening planning for children's mental health. This will ensure that the strategy and recommendations provided by this Plan are implemented in a way that also considers the unique strengths and challenges of each region. The process of developing regional plans in consultation with health authorities, school districts and other partners will provide regions with a forum to bring together the wide variety of players who support children and families who

are at risk of or are experiencing mental illness and can provide the foundation for the development of regional and local "children's mental health networks" that will ensure continued coordination of services at these levels. It is critical that people with a background and expertise in children's mental health provide leadership to these networks at all three levels.

Improved Access to Internal MCFD Resources

In the initial creation of the Ministry for Children and Families, the intent was to create an integrated range of services to meet the broad needs of children who are at risk from a variety of external and internal factors, and to reduce or eliminate the stovepipe approach that has fragmented services for children and their families.

Opportunities continue to exist to achieve this integration; however, it requires that MCFD make substantial changes to the ways in which services are accessed. Re-focusing some residential services from children in care to children with mental disorders is one example of change that can improve integration.

Another area in which internal integration of mental health with other sectors of the ministry is essential is in Early Childhood Development. Because of the efficacy of intervening early with very young children who are at risk, and because of the specialized knowledge and skills of mental health clinicians in mental, emotional, and behavioural development, it is critical for the Early Childhood Development sector to include a mental health specialist as a part of the team.

Information Management

The development of this Plan has demonstrated very clearly that our current information management capacity is not adequate for the need. Because of the amount of time required to implement a new information management system, it is recommended that aspects of information planning begin in Phase 1, though complete expenditure of the funds will extend into Phase 2.

First, this funding will allow us to implement an information management tool for children's mental health services. The planning for this activity has already begun with MCFD's Systems Services Branch. Funding will allow us to continue the process.

Second, this funding will support the development and implementation of an electronic intake, screening and follow-up application that is based on outcomes rather than outputs. Such an application would allow us to 1) make intake and prioritizing decisions consistent across the province, 2) track all of the children that are served, whether by MCFD employees or by contracted agencies, 3)

assess the impact of our work based on the outcomes for children and families and 4) link findings with larger (e.g., national) children's mental health databases.

Third, we need to be able to document our practice in Integrated Case Management (ICM). ICM refers to the process of working collaboratively when a child requires services from a variety of agencies. The purposes are to provide more coordinated and effective services and to improve outcomes for children and families. In almost all circumstances when children's mental health is seriously impaired, they do in fact require services from more than one agency. This initiative contributes to improved outcomes specifically for children who are served by many sectors, and consequently is ideally suited for joint funding.

This funding is intended to improve the practice of collaborative service planning (also commonly referred to as "wrap around services") for individual clients. One significant support is the development of an electronic application that would allow for documentation, tracking and evaluation of the practice of ICM. While not funded in this plan, feedback from the field indicates that the availability of regional specialists to encourage implementation of ICM practice, to organize training and support activities, and to provide consultation to ICM teams as required would significantly improve ICM practice.

Finally, we need to improve significantly on the information that is available about children with mental illnesses who receive services for their disorder from MOHS funded resources (e.g., hospitals, psychiatrists, family physicians). While MOHS can provide some information, it is confounded by many factors and consequently not currently useful in making planning decisions. It is critical that the information management system described above has the capacity to interface with existing MOHS information.

5.3 Phase 2

The primary focus of Phase 2 of the Plan is to substantially narrow the gap between need and capacity in the children's mental health service system. The first priority will be a major investment to develop a basic level and range of core services in every region. A second priority will be continued support for researching and using evidence-based practices in BC's children's mental health service. The final priority is the continued implementation of the information management system that will begin in Phase 1.

Currently we know the priorities and direction of Phase 2; however, it is anticipated that substantive planning for Phase 2 will continue during and be informed by the implementation of Phase 1 initiatives. The Phase 2 initiatives described below, therefore, are general descriptions only.

5.3.1 Providing Treatment and Support

Evidence-based Practice

In Phase 2, funding to support evidence-based practice will provide a final phase of initial training to ensure that mental health clinicians across the province have a good understanding of the current recommendations for practice and that mental health leaders are trained in supervision and mentorship to support the front-line clinicians. A smaller portion is also identified as on-going funding to maintain and enhance this knowledge level as research provides new findings.

Basic Level and Range of Core Services in Every Region

Currently in BC there is wide variation in the accessibility of appropriate children's mental health services. The continuum of core services presented below describes a minimum range of options that need to be available to mentally ill children and their families to meet their specific needs. In Phase 1, Early Intervention, Community-Based Assessment, Counselling and Treatment, Residential Services and Maples refocusing were early approaches to begin to provide this continuum.

This Phase 2 funding is intended to further reduce the gap between current service capacity and identified need. Regions should use this continuum as a foundation for developing their regional plans for children's mental health services, recognizing that the particular configurations of services will vary from region to region in order to reflect their diversity. This funding will provide for a basic range of children's mental health services available in each region as follows (see Section 4.4.1 for more detailed descriptions of these services):

- Consultation—Children's mental health clinicians to provide clinical and mental health consultation to families, communities and other service providers.
- Community-based assessment, counselling and therapy services—Children's mental health clinicians to provide these services.
- Home-based and outreach services—Skilled workers (e.g., child and youth care workers), supervised by specialized children's mental health clinicians, to provide supports in homes, schools, and the community.
- Family development services—Funding for individualized services for the unique needs of families of mentally ill children (e.g., respite, parenting groups).
- Day treatment—Funding for community-based day treatment spaces.
- Crisis Intervention and Stabilization—Funding to enable CYMHS to partner with other crisis services (e.g., in hospitals, crisis lines) to

extend the services and provide training and specialization in children's mental illness.

- Residential services such as therapeutic family care, crisis stabilization and supported independent living—Funding for specialized living circumstances staffed or supported by workers who are skilled in working with mentally ill children.
- Acute care—While this Plan does not address funding for acute care services, the overall goal of the Plan is to reduce pressure on those services for children with mental disorders by increasing the range and capacity of community-based services. Acute care services designated for mentally ill children should be available in each region, however, which will require, at the least, some redistribution of existing resources.

  We recommend that the Children's Mental Health Network (see recommendation 4.4.1) be given the task of evaluating the adequacy of the current inpatient hospital component for children's mental health. The Network needs to ensure that not only is there adequate capacity but that the capacity is distributed equally among the health authorities, so that a child living in any part of the province has equitable access to in-hospital services. In addition, the Network should ensure that there is equitable access to the inpatient and outpatient tertiary care services at BC's Children's Hospital for all children in the province

5.3.2 Reducing Risk

Carrying over from Phase 1, the role of clinical and mental health consultation will continue to support families and communities in reducing risk.

Early Identification
In Phase 2, additional on-going funds will continue to build on the resource base that provides community support and liaison services for the broad children's mental health system in order to identify children at risk of developing mental illnesses at early stages, either in age or in onset of illness.

Early Intervention
As in Early Identification, these funds will provide incremental on-going support for intervening early in those circumstances where children are identified as having or are in the early stages of developing a mental illness.

5.3.3 Building Capacity

In Phase 1, early attention was focused on building partnerships, consultation, a resources library, and the refocusing of some family development services. These initiatives will continue to be supported.

5.3.4 Improving Performance

The improvements initiated during Phase 1 (Children's Mental Health Network, regional planning, and improved access to internal MCFD resources) will continue to be supported.

Information Technology

Some of these funds will be used to support the on-going, or operating, costs for the information management system developed in Phase 1 (and extend into Phase 2). In addition, we will develop the ability to use information technology supports for distance consultations (TeleHealth), networking, training and education. Funding will provide e-learning applications, discussion boards and communications technology.

CHAPTER 6

PERFORMANCE PLAN

6.1 Resource Investment Strategy

Investments directed at improving children's mental health services will be phased in over the five years of the Plan. Phase 1 will occur over the next two years and Phase 2 over the following third to fifth years. Phase 1 will concentrate on the implementation of evidence-based practice, and on building the planning and service coordination infrastructure necessary to refine and optimize Phase 2 investments.

The majority of new resources needed to support the Plan will be required in Phase 2. This phase will develop an accessible, client-focused platform of core community children's mental health services, including mental health consultation to support risk reduction and capacity building, across the province. The Plan will achieve improved effectiveness of existing community resources and reduce dependency on high cost hospital-based and institutional care.

While this Plan provides the framework and strategic direction for improving children's mental health services in BC, the exact nature, location and timing of the proposed service enhancements and their measures will have to be determined over the next two years, in conjunction with Phase 1 improvements in information and planning.

Once fully implemented, these investments will result in double the number of mentally ill children and their families who will be helped each year to overcome the tragic effects of serious mental illness. An additional 20,000 children with or at risk of developing mental disorders will be provided treatment and supports annually.

6.2 Objectives and Measures

As outlined in Chapter 4, the Plan calls for improving the mental health of children by

- expanding the quality and quantity of treatment and support services,
- reducing risk factors in children and families, strengthening resilience and enhancing protective factors,
- building individual, family and community capacity, and
- improving service system performance and accountability.

Examples of possible performance objectives and measures associated with these strategies are outlined in the following pages. It is anticipated that the objectives and measures will be further developed and modified as more detailed implementation planning occurs. It also needs to be understood that no one

indicator can be taken as a measure of an improved child and youth mental health system. The comprehensive information management system described in Sections 4.4.2 and 5.2.4 will need to be planned and developed to provide a clear picture of the success of the Plan.

Strategy	Objective	Measure	Outcome
Improving Treatment	• Increase the number of children treated and supported in community settings	• # of children treated and supported in the community	• Maximum efficiency and effectiveness of resources deployed to achieve improvements in children's mental health outcomes
	• Reduce the length of stay for specialized adolescent psychiatric units	• Length of stay and patient days	
	• Reduce general acute hospital bed utilization for psychiatric illnesses	• Bed utilization and number of admissions to general hospital beds for mental illness	
	• Annual improvement in treatment results relative to current funding levels	• Standardized functional outcome rating system implemented throughout province	
		• Client and family rated improvement in outcomes	

Strategy	Objective	Measure	Outcome
Reducing Risk	• Increase the ability to identify at-risk children	• Per cent increase in number of at–risk children who are identified and receive service	• Children's capacity to overcome less severe forms of mental illness is enhanced
	• Reduce risk profile for identified high risk children	• % reduction in risk factors for identified children	• Children are high functioning despite the presence of risk factors
	• Increase resiliency for identified high risk children	• % improvement in protective factors	
	• Reduce the incidence and impact of mental disorders in children by intervening early	• Number of early intervention programs and interventions	
	• Decrease suicide and suicide attempts	• % reduction in suicides and suicide attempts	

Strategy	Objective	Measure	Outcome
Building Capacity	• Increase in the knowledge and ability of families and communities to support children with mental disorders	• % increase in number of training and education events attended by families and the public	• Knowledge and skills of families, children and the general public are enhanced • Stigma of mental illness is reduced
	• Expansion of service partnerships with broader child and family serving system	• Increased access to Family Development and Residential resources • Number of service providers including primary care practitioners and schools provided consultation by children's mental health • Per cent increase in number of children who access targeted prevention programs	• Responsibility for children's mental health is shared
	• Increase the support that families of mentally ill children receive from self-help and advocacy groups	• Number of families referred to self-help and advocacy groups by clinicians • Number of self-help and advocacy groups	• Families and service providers are supported by mental health
	• Improve the responsiveness of mental health to ethno-cultural individuals, families and communities	• Demographic characteristics of clients	• The population served reflects the ethnic cultural diversity of the province
	• Collaborate with Aboriginal communities to develop capacity to improve mental health outcomes	• Number of collaborative initiatives	• Aboriginal leadership in mental health

Strategy	Objective	Measure	Outcome
Improving Perform-ance	• Increase in the number of mentally ill children who are helped to overcome their mental illness through introduction of evidence-based practice	• % increase in # of diagnosed mentally ill children who are helped each year	• Reduction of the number of children with mental disorders who are not treated
	• Client focused inter-jurisdictional service planning and coordination at local, regional and provincial level	• % of children with service plans developed in collaboration between two or more child serving jurisdictions	• Efficient and effective mobilization of resources to support the mental health of children

	• Information management capacity to reinforce the delivery of evidence-based practice to individuals, families, and communities and to provide necessary performance management information	• Capacity to measure the following:
		  • % of standardized assessments
		  • % of evidence-based practice approaches
		  • % of clients demonstrating improvement in function
			• Transparent and accountable service provided as effectively as possible to reduce the harm caused by mental illness in children
			• A clear understanding of need and priority

	• Promulgation of evidence-based practice knowledge	• # of clinicians trained • # of families educated • # of community education forums • # of clients educated • % of MH clinicians complying with best practice guidelines (determined through supervision and audits, including chart audits)	• Evidence-based practice available throughout BC

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Child and Youth Mental Health
Consultation Process and Summary of Results

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Executive Summary

Introduction

In November 1999, Mike Corbeil, Deputy Minister for Children and Families announced a provincial strategy to develop the *Child and Youth Mental Health Plan* with the following objectives:

- Affirm a shared vision internally and with key ministry partners and a shared understanding of roles within the larger system of services
- Raise the profile of Child and Youth Mental Health Services with MCF staff and service partners externally
- Commit to a shared action between partners by addressing concerns

The *Child and Youth Mental Health Plan* has been developed based on an extensive consultative process, and affirms a mandate and program description for Child Youth and Mental Health Services within the Ministry and as part of the larger system of mental health services. The Plan also identifies directions in planning that include a range of strategies that address:

- Analysis of the gaps, overlaps and omissions in current services, within the context of the current Ministry's developmental priorities
- Identification of policy and standards development priorities that are required to facilitate the process for service development
- Identification of the required resources, program development priorities and service partnerships required by the Ministry over the next five years to further the vision of a comprehensive child and youth mental health care system in British Columbia
- Directions for future research (e.g. efficacy of treatment methods)

Purpose

The purpose of this document is to provide a summary of the feedback received through consultation across British Columbia with representatives from: Aboriginal communities; Ethnocultural organizations; the formal system of Child and Youth Mental Health Services within the Ministry for Children and Families which includes staff from Mental Health Centres, Youth Forensic Psychiatric Services, Maples Adolescent Centre, and the Family Court Centre; MCF across program staff (non mental health) which includes Addictions, Youth Justice, Community Living, Child Protection, Adoptions, and Guardianship; and the broad service delivery system of care which includes child and adolescent psychiatrists and other physicians, Ministry of Health, Ministry of Education, Ministry for Social Development and Economic Security, Regional Health Authorities, Community Health Services Societies, and key stakeholders.

Process

Meetings were held with representatives from key program areas of Policy Development within the Ministry for Children and Families, to establish a plan for the mental health plan consultation process.
Consultation with the individuals and groups described previously was achieved through distribution of the *Directions in Planning* document and questionnaires, and through focus groups, teleconferences, and individual interviews. Focus groups were facilitated by Mental Health Consultants working in the Mental Health and Youth Policy Section in the Ministry for Children and Families. Participants were asked to respond to questions related to the *Directions in Planning* document that were pertinent to their area of work and responsibility, and distribution of the appropriate documents occurred prior to each consultation. Key informants were interviewed by the Manager and/or Director of the Mental Health and Youth Policy Section.
A total of 712 questionnaires were distributed, focus groups and teleconferences were held, and key informant interviews were conducted.
The resulting qualitative and quantitative data was analyzed to determine priorities and themes related to the mental health system of care for children, youth and families, and was incorporated into the further development of the *Child and Youth Mental Health Plan*.

Feedback from children, youth and families in relation to the *Directions in Planning* document was obtained through a separate process. The Ministry for Children and Families contracted with the Canadian Mental Health Association (CMHA), BC Division, who conducted focus groups separately with Consumer Advocacy and Support Groups, with families, and with youth, in Williams Lake, Cranbrook, Duncan, Terrace and the Lower Mainland. This information is reflected in a separate document titled *The Importance of Experience: Children, Youth and Families Comment on Mental Health Services,* and the priorities and themes were incorporated into the updated *Child and Youth Mental Health Plan*.

Findings

The following common themes were identified throughout consultations with individuals and groups, described previously, across the system of care related to mental health services for children, youth and families.

- Need for the development of infrastructure to support the implementation of changes within the current Child Youth and Family Mental Health system, and the facilitation of collaborative partnerships.

- Need to involve clients and families in an advisory capacity on a provincial, regional and local level, and to provide additional support and education to families whose children have mental health needs.

- Specialized, qualified, multidisciplinary mental health staff are required to deliver a range of mental health services across the province.

- Improved coordination of services within MCF e.g. mental health residential resources, coordination of service for complex dual diagnosis cases is required.

- Improved partnerships are required with Ministry of Health, Ministry of Education, physicians, and other system partners e.g. bridging the gap between adult and child and youth mental health systems to address issues of common concern such as transitional services for youth age 15-24, improved school-based services, early screening and other mental health services for children under 12 years.

- Ongoing educational needs such as:
  - Education for the general public to increase awareness of CYMHS services and mental health issues, and reduce associated stigma.
  - Specialized education for mental health clinicians e.g. in cultural sensitivity, treatment for dual diagnosis, Integrated Case Management.
  - Mental health education for other service providers e.g. school counselors and teachers, physicians, alcohol and drug counselors.

- New services can not be provided without substantial additional resources.

Conclusion

The consistent expression of the need for additional resources can not easily be ignored if the wellbeing of our children, youth and families is to be considered. Clearly there is a great deal of knowledge within the service delivery system and in the community of the current needs and priorities, including the importance of the required infrastructure and relationships to support further development.

The healthy future of many children, youth and families depends on the shared commitment of service providers, consumer groups, and provincial ministries to implement the *Child and Youth Mental Health Plan*.

Consultation Summaries

Aboriginal Consultation

The consultation process with Aboriginal groups included meetings with the Regional Aboriginal Services Managers Forum, and Directors of First Nations Family Service Agencies, as well as with consumers and service providers in Port Simpson and Prince Rupert, including representation from Hartley Bay. Feedback was also received through discussion with an aboriginal family service agency in Victoria. Following is a summary of their collective comments.

- Some communities have high levels of unemployment, alcohol abuse, school absenteeism, and suicide risk.
- There is significant stigma associated with mental illness within small communities, and often lack of trust toward professionals.
- Lack of access to specialized mental health services e.g. psychiatry, schizophrenia services and support, and inpatient beds, due to geography (particularly in fly in communities), lack of funding, and administrative barriers (e.g. referral criteria).
- Lack of funding and support in rural communities that is needed to facilitate receipt of services in larger centres, and poor coordination of care when it does occur.
- Difficulties with recruitment, retention, and continued training for mental health clinicians in smaller communities.
- Desire for increased clinical training and recruitment of First Nation's people to provide mental health services.
- High demands placed on current service providers within the community limits their focus to crisis counselling and advocacy.
- Need for education and support to families whose children have mental health needs
- Need for both better access to mental health centres with culturally sensitive staff, and contracted aboriginal agencies that can provide mental health services.

Ethnocultural Consultation

Consultation in relation to multicultural issues occurred through a meeting with the MCF Provincial Ethnocultural Advisory Committee in Victoria, and a focus group held in Kamloops with members of the Kamloops Ethnocultural Advisory Committee. Their priority concerns were as follows.

- Lack of knowledge regarding mental health/illness and the availability of related services. Need to provide education in different languages for all ages in 'normalized' settings e.g. schools and ethnocultural service agencies, and through the media, about early signs of mental health problems, mainstream cultural norms, available services, and confidentiality.

- There is variability in cultural norms between ethnic groups.

- Shame and loss of family honour is associated with mental health difficulties.

- Intergenerational conflict exists related to cultural adjustment, particularly between teens and parents, which contributes to high rates of depression, anxiety, drug and alcohol abuse and suicide among ethnocultural teens.

- Often there is fear of authority, and poor understanding regarding the roles of people in these positions (e.g. police, CYMHS clinicians compared with Child Protection social workers).

- Understanding of legal rights is poor, and there is fear of repercussions if they seek help, such as being refused employment, insurance, or housing, or being sent back to their country of origin.

- In order to provide culturally sensitive clinical service there is a need for experienced and appropriate interpreters (not family or friends), culturally relevant assessment tools, staff training and hiring practices that include cultural diversity, and stronger links between Child and Youth Mental Health Services and ethnocultural service agencies.

Child and Youth Mental Health Staff Consultation

Staff working in the formal mental health system within MCF which includes Mental Health Centres, Youth Forensic Psychiatric Services, Maples Adolescent Centre, and the Family Court Centre; and Child and Adolescent Psychiatrists throughout the province, provided feedback through written responses to questionnaires related to the *Directions in Planning* document.

Child and Youth Mental Health staff working in Mental Health Centres consistently expressed concern with the overwhelming demands for service and their ability to respond largely to only the most serious, emergent cases because of limited staff resources. Education and support for families, and early intervention are areas that often don't get attention due to the pressing needs and time commitment required of the more urgent cases.
The following areas of concern were also consistently highlighted.

- Development of infrastructure is a priority in order to support the strengthening of Child and Youth Mental Health teams, to facilitate essential partnerships between Ministries and other Programs, to improve equitable access to services across regions, and to ensure consistency in the delivery of services based on standards of best practice.

- Additional resources must be provided to enable the creation of programs to meet identified needs such as mental health residential resources, transitional services for youth age 15-24, services for children under 12 years of age, and consultation and support to other MCF Programs. Funding is also required to enhance existing services that are chronically understaffed, particularly given long waitlists and the knowledge that children, youth and their families are presenting with increasingly severe and complex mental health needs.

- Strong statements about the importance of returning and/or maintaining the integrity, and recognizing the expertise of specialized, multidisciplinary mental health teams, through co-location of mental health clinicians, appropriate guidelines for clinical supervision, development of clinical policies by qualified mental health professionals, and ongoing specialized training.

- Concerns regarding the need to clearly differentiate the roles of CYMHS from those of MCF Protection and MCF Forensic Services. CYMHS staff feel that the ability to develop therapeutic relationships is frequently compromised due to confusion experienced by families, and reluctance to access services because of worries that families have about confidentiality and possible loss of control over the care of their children.

- Discomfort with the inclusion of confidential mental health information in a larger information systems database, given concerns about potential inappropriate access and use of this information by others.

See supporting data in Appendices A, C, E, F, G, H, I.

Ministry for Children & Families Across Program (Non-Mental Health) Staff Consultation

Consultation with the Ministry for Children and Families Across program staff occurred through focus groups held in Nanaimo and Prince George, and . through questionnaires that were distributed to Child Protection, Adoptions, Guardianship, Community Living, Addictions, and Youth Justice.
These groups have acknowledged the expertise of Child and Youth Mental Health staff and the benefit that could be provided to their clients through mental health consultation to their programs. They feel, however, that they are often not able to benefit from that expertise due to unavailability of CYMHS staff to provide consultation to other programs. They also discussed the following issues.

- The development of administrative infrastructure is essential to facilitate the formation of collaborative partnerships, the implementation of new services and to support the delivery of current CYMHS.

- Access to consultation with qualified mental health professionals is needed to support the delivery of other MCF services to children, youth and families e.g. Child Protection Services, Forensic Services and also to support the functioning of Integrated Case Management.

- Additional funding is required to augment existing Child and Youth Mental Health Services and reduce waiting lists, as well as to develop new services, particularly transitional services for youth age 15-24 years, services to meet the needs of children and youth with complex dual diagnoses, mental health residential resources, and services for children under the age of 12.

- Need to address issues related to access to services such as the variable availability of services regionally, clarification of referral pathways and referral criteria, and improved physical access to services particularly for youth.

- Need for specialized training for mental health staff that is specific to regional needs.

- Mental health training is required for MCF Across Program non-mental health staff e.g. social workers, drug and alcohol counselors, child and youth care workers, and for foster parents and community partners e.g. school counselors, physicians.

- Support the use of Integrated Case Management for children, youth and families when they have complex dual diagnoses.

See supporting data in Appendices A, D, E, F, G, H, I, and J.

Broad Service Delivery System Consultation

Consultations with those working in the broad system of care included service providers from across the province, and feedback has been received through focus groups, teleconferences and written responses to questionnaires. Focus groups and teleconferences held in the Lower Mainland included representatives from the Upper Fraser, South Fraser, Simon Fraser, Vancouver, Burnaby, Richmond, and North Shore regions. Focus groups and teleconferences held in the interior included representatives from Kelowna, Kamloops, Vernon, Salmon Arm, Nelson, Grand Forks, Cranbrook, Creston, and Penticton. These groups included Child and Adolescent Psychiatrists, paediatricians, and staff from the Ministry of Education, Ministry of Health, Ministry for Children and Families, and Ministry for Social Development and Economic Security. A teleconference was also held with representatives from Community Health Boards and Community Health Services Societies, and written feedback was received from the Mental Health Advisory Council to the Minister of Health.

The broad service delivery system was unanimous in their support for closer links between CYMHS and other service providers, particularly Ministry of Health and Ministry of Education. In addition, they identified the following issues.

- Need to strengthen infrastructure to support links between CYMHS and the Ministry of Education, and CYMHS and the Ministry of Health to address issues of common concern e.g. continue to support the role of the Inter-ministry Child and Youth Mental Health Policy Committee (IMPC).

- Concern about CYMHS's loss of visibility, loss of connection with partners such as Ministry of Health and Ministry of Education and confusion with other Ministry partners such as Child Protection, since CYMHS became part of MCF.

- Significant need for additional resources for development of priority programs to address gaps in service. These include; early intervention and supportive services for children and youth of all ages and their families, services for children under 12 years, transitional services for youth age 15-24 years including hospital based services, mental health residential resources, links between hospital based and community based mental health services, school-based mental health services, and coordination of services for complex dual diagnosis cases.

- Need to allow for regional and cultural differences, and consider more flexible approaches in the development of resources and provision of services e.g. for aboriginal families. Support the need for increased cross-cultural representation within the complement of trained mental health staff.

See supporting data in Appendices B, K, and H.

- Ensure the involvement of families, foster parents, caregivers and front line staff in the development of resources and in ongoing decision making regarding service delivery e.g. through representation on the IMPC. Develop consultation processes that are comfortable, and support effective participation of children, youth and families.

- Require education for the public and for other service providers e.g. physicians, school counselors, to raise the awareness of mental health issues and Child and Youth Mental Health Services, and improve the early identification of mental health difficulties and receipt of service.

- Provide education for mental health clinicians to support the delivery of a range of specialized services e.g. cultural sensitivity, dual diagnosis.

- Facilitate the use of Integrated Case Management (ICM) to support children, youth and families when they have complex mental health needs e.g. dual diagnosis

CONCLUSION

Staff, physicians, and other representatives from communities across the province have clearly demonstrated their commitment and interest in the continued development of mental health services for children, youth and families through their participation in this consultative process. They have shared a wealth of knowledge and experience that provides valuable guidance to the task of implementing change. Their overwhelming message is that action to increase resources and service is long overdue, and should be seen as an investment in the future of the province.

The need for effective consultative partnerships with children, youth and families to facilitate the inclusion of their perspectives in the development and provision of services was highlighted. Many agree that prevention, early intervention and increased supports for children, youth and families can interrupt the progression of mental health difficulties, significantly enhancing the quality of life for many individuals throughout their life span, and over time can be expected to reduce the needs for costly crisis intervention services. The development of flexible service delivery models and other specialized services designed with sensitivity to diversity in culture, values, beliefs, and needs, are required to better meet the varied clinical challenges presented by groups such as high risk, marginalized youth, and children and youth with complex dual diagnoses. Expanding the range of residential services will enable the provision of appropriate residential treatment and care, and reduce the use of expensive hospital based services due to the lack of other more suitable options.

The strengthening of collaborative partnerships within the Ministry for Children and Families and with other Ministries at both regional and provincial levels is seen as essential to enable the expanded comprehensiveness and improved efficiency of services for children, youth and families. Access to services that are most appropriate to specific clinical needs throughout the age span, and continuity of care will be improved with increased awareness regarding available services, enhanced communication between professionals, and more flexible service boundaries. Planning, allocation of resources, and development of services will be coordinated more effectively and efficiently, with the result that gaps and duplications in service will be more easily identified and resolved. A greater sense of teamwork and shared responsibility for clients will emerge and facilitate the implementation of integrated case management. The introduction of new supports such as services related to hospital transitions can be expected to reduce the need for re-admissions in many cases.

Job descriptions that articulate the unique skills and roles required of Mental Health service providers will guide staff practice and support the hiring of qualified multidisciplinary teams. Effective recruitment will ensure that both rural communities and city centres have better access to the staff and psychiatric services that they need. The use of innovative approaches such as 'telehealth' will expand the capacity to reach rural communities to provide service as well as education.

As the implementation of the Mental Health Plan progresses, the demands on individual CYMHS staff will become more manageable and will allow them to offer their specialized expertise across the continuum of care within the mental health system. They will also be better able to meet the consultation and education needs of their professional partners. Ongoing education and training will raise staff morale and play a vital role in the maintenance of high levels of professionalism and standards of practice. Public education about mental illness, and the delivery of services in normalized settings such as schools will help to reduce the stigma that is often associated with receiving mental health services, and contribute to the creation of an environment of acceptance and support in our communities.

The dedication of the staff surveyed throughout the consultation is very evident, however they expressed fatigue and frustration related to their inability to provide services to the extent that they are required. Many individuals and groups were passionate in their appeals regarding the need for more funding for mental health services given the long waitlists and the evidence that children, youth and families are presenting with increasingly severe and complex needs. Clinicians indicate that they are often faced with situations where they are offering assistance that is too little, too late. They made strong statements about the need for action to be taken that will provide immediate support at the service delivery level, rather than directing funding to further review and analysis. Mental health professionals believe that the service needs are clearly identified, and that they should be met without delay.

Child and Youth Mental Health Directions –
Consultation Process and Summary of Results

APPENDICES

STRATEGY PRIORITIES IDENTIFIED BY CYMHS AND MCF ACROSS PROGRAM STAFF - QUESTIONAIRES

The following 16 priorities have been identified through consultation with CYMHS and MCF Across Program staff.

Common Issues in the Top Ten Priorities for MH and MCF Across Program Staff;

Issue #11: Mental Health Residential Resources

Issue #22: Transition Services for Youth Aged 15-24 Years

Issue # 4: Policies, Procedures & Operational Standards

Issue #15: Identifying and Serving the Young Population

Additional Issues in the Top Ten Priorities for Mental Health Staff;

Issue # 5: Standardized Recruitment Strategies & Job Descriptions

Issue #13: Policy Guidelines to Link Hospital Based & Community Mental Health Services

Issue # 6: Training and Educational Strategies

Issue #12: Bridging Gap Between Adult and Child & Youth Serving Mental Health Systems

Issue #14: Balanced System of Inpatient and Residential Resources

Issue # 1: Workload and Resource Deployment

Additional Issues in the Top Ten Priorities for MCF Across Program Staff;

Issue #24: Coordination of Service for Complex Dual Diagnosis Cases

Issue # 8: Clinical Support and Consultation to MCF Programs

Issue # 3: Equity Along the Continuum of Care

Issue #18: Mental Health Services for Marginalized Youth

Issue #17: School Based Mental Health Strategies

Issue #23: Mental Health Issues in Relation to 'Safe Care' Options

STRATEGY PRIORITIES IDENTIFIED BY BROAD SERVICE DELIVERY SYSTEM FOCUS GROUPS – LOWER MAINLAND AND TOKO

The following 12 priorities have been identified through focus groups held in the TOKO region and the Lower Mainland.

Common Issues in the Top Ten Priorities for TOKO and the Lower Mainland:

*Issue #11: Mental Health Residential Resources

*Issue #15: Identifying and Serving the Young Population

*Issue #22: Transition Services for Youth Aged 15-24

Issue # 3: Equity Along the Continuum of Care

Issue #17: School Based Mental Health Strategies

Issue #12: Bridging Gap Between Adult and Child & Youth Serving Mental Health Systems

Issue #18: Mental Health Services for Marginalized Youth

Issue #24: Coordination of Service for Complex Dual Diagnosis Cases

Additional Issues in the Top Ten Priorities for the TOKO region:

Issue # 6: Training and Educational Strategies

Issue # 7: Identified Pathways to Service

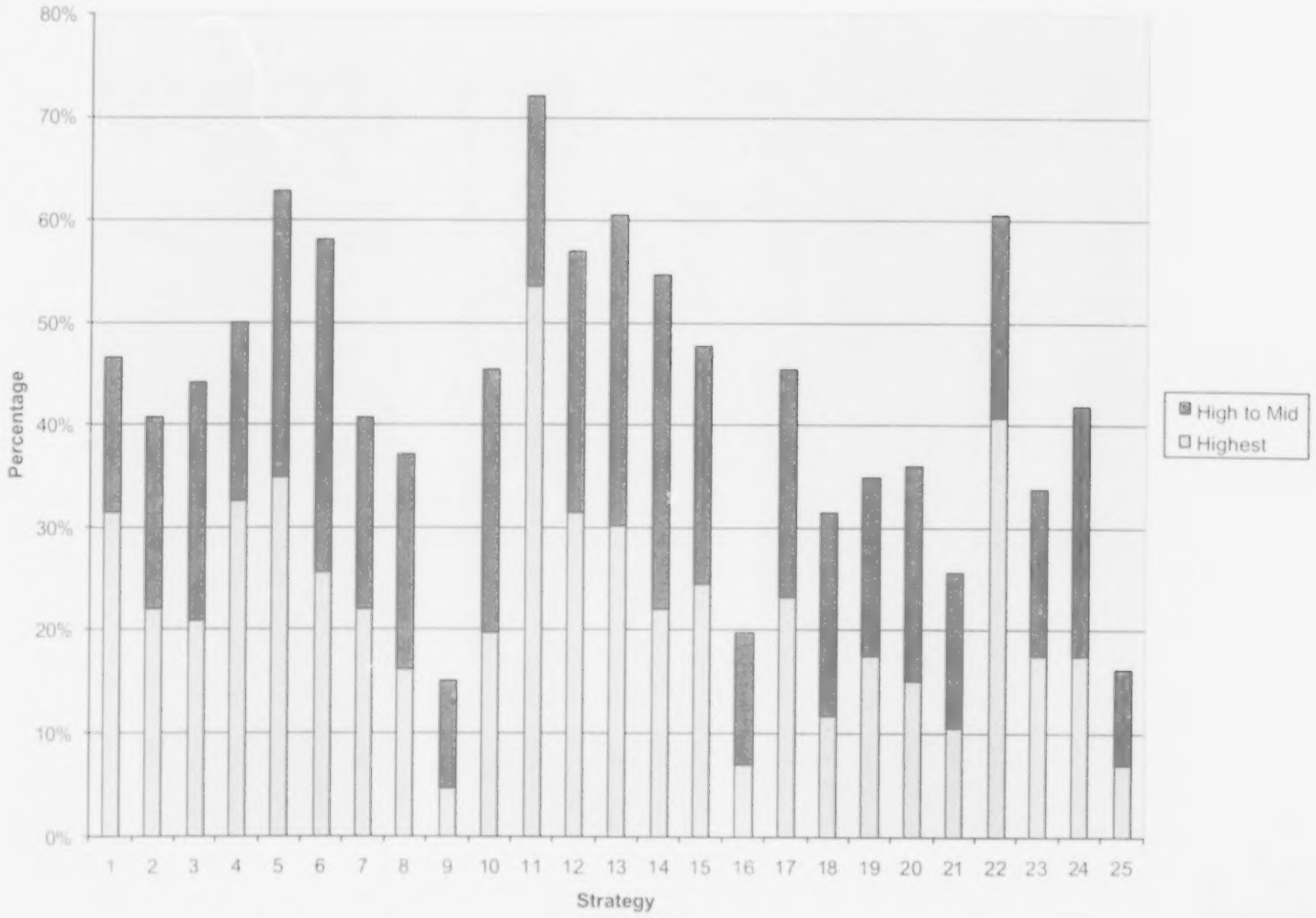
Additional Issues in the Top Ten Priorities for the Lower Mainland:

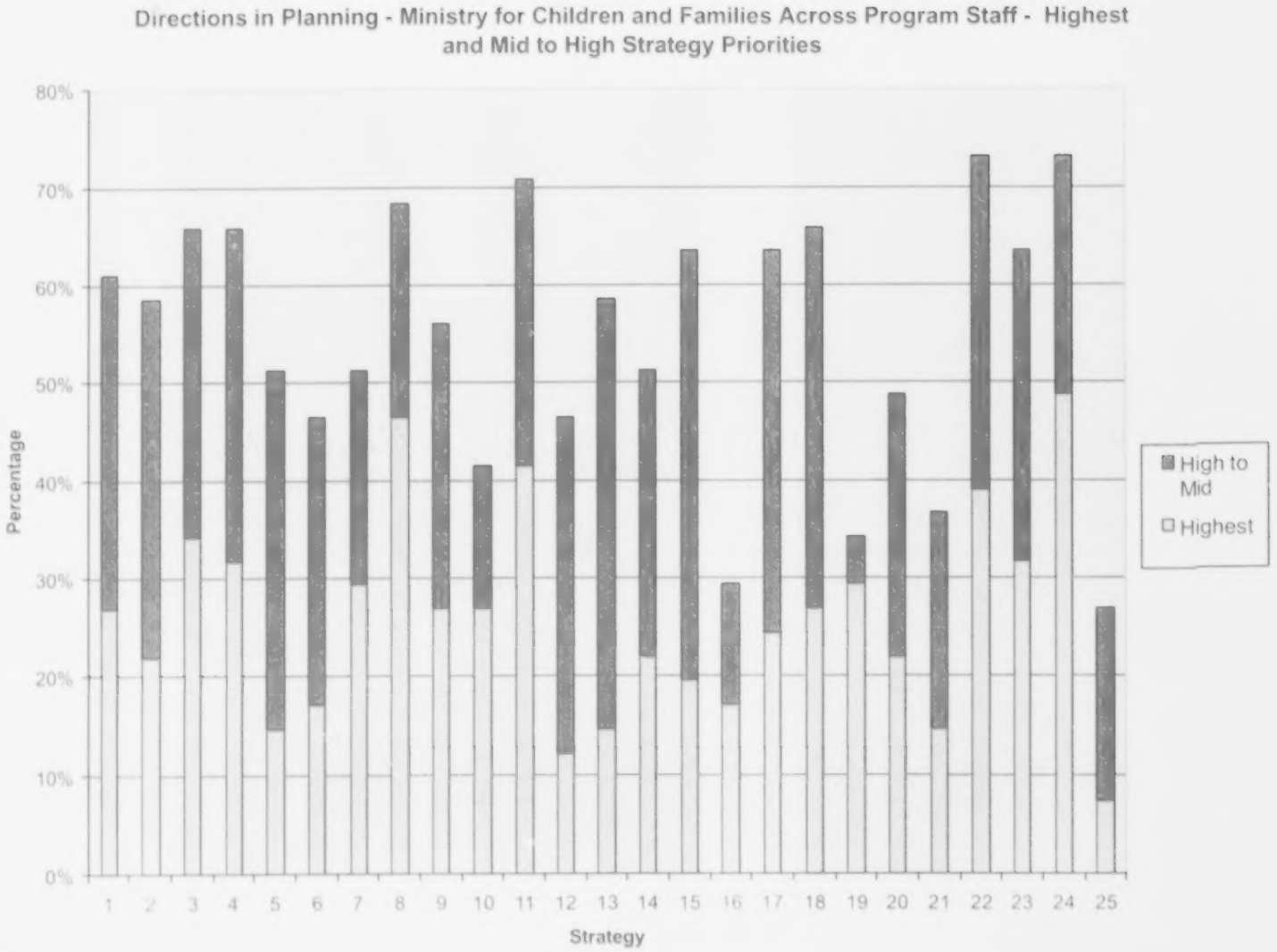
Issue #14: Balanced System of Inpatient and Residential Resources

Issue #13: Policy Guidelines to Link Hospital & Community Mental Health Services

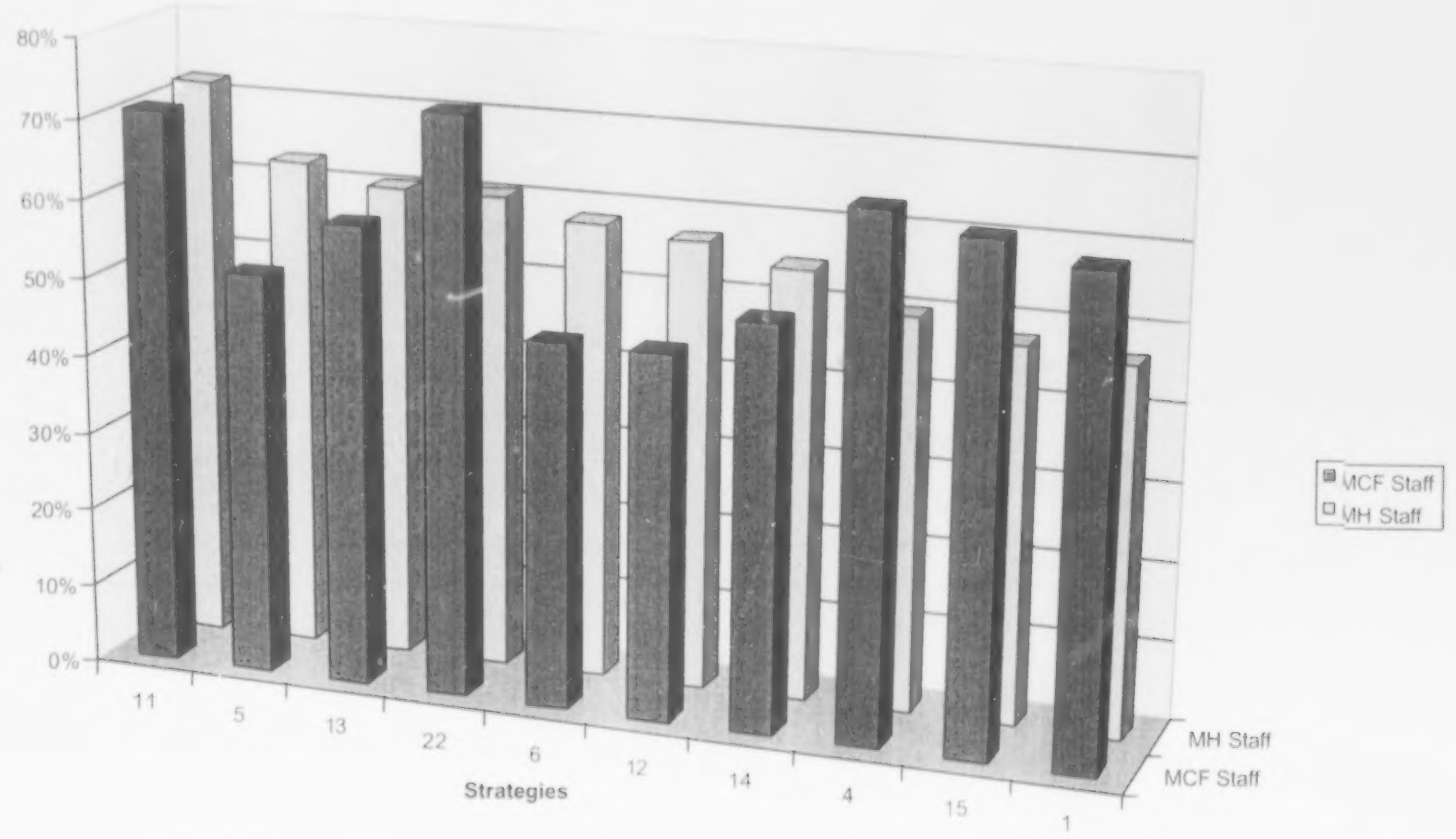
identifies priorities that are also common to <u>both</u> Child and Youth Mental Health staff, and Ministry for Children and Families staff.

Directions in Planning - Mental Health Staff - High and Mid High Strategy Priorities



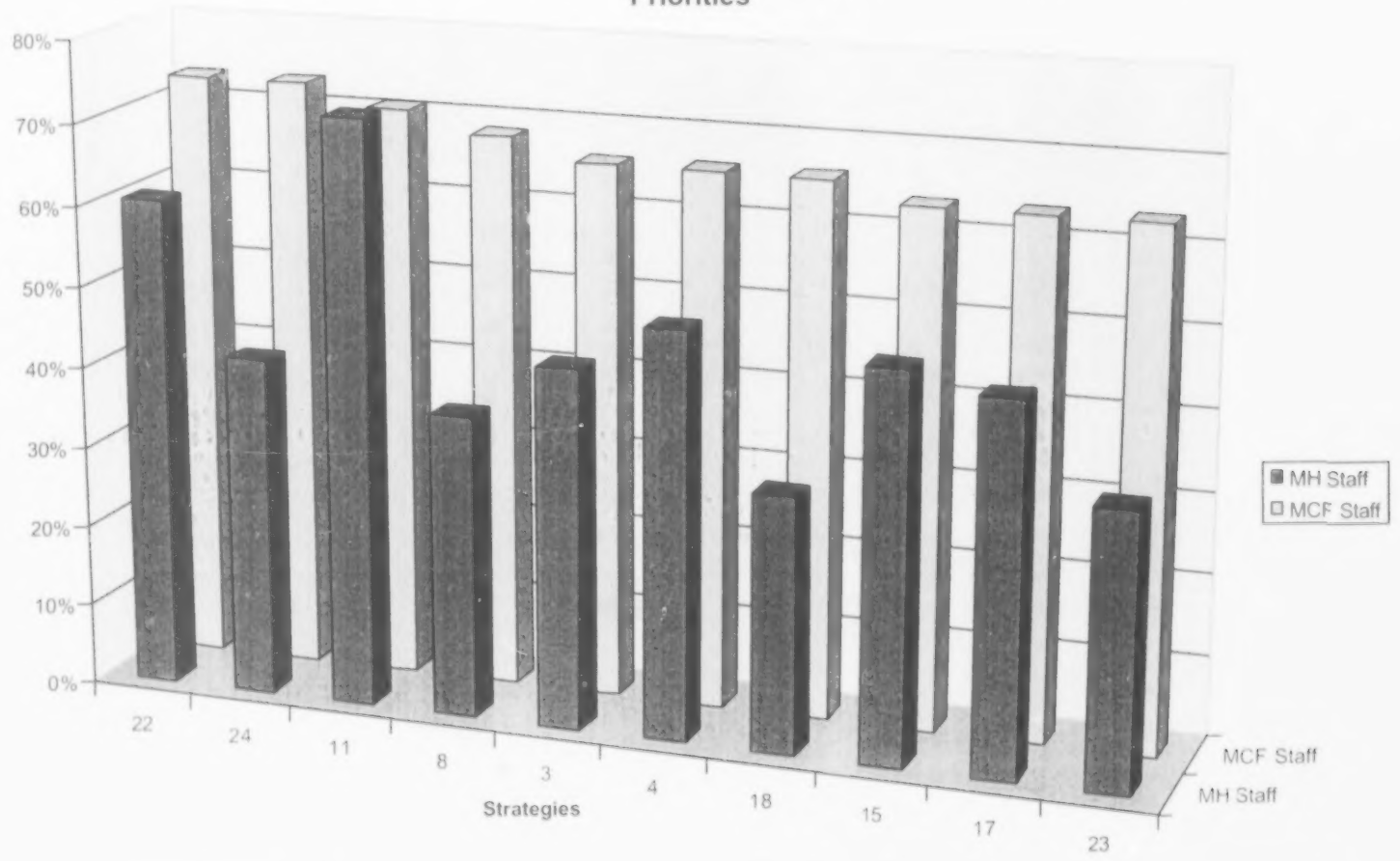

Directions in Planning - Ministry for Children and Families Across Program Staff - Highest and Mid to High Strategy Priorities
80%
70%
60%
50%
40%
30%
20%
10%
0%
Percentage
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25
Strategy
High to Mid
Highest

Mental Health Staff - High and Mid to High Strategy Priorities Compared to MCF Priorities



	11	5	13	22	6	12	14	4	15	1
MCF Staff	71%	51%	59%	73%	46%	46%	51%	66%	63%	61%
MH Staff	72%	63%	60%	60%	58%	57%	55%	50%	48%	47%

MCF Staff - High and Mid to High Strategy Priorites - Compared to MH Staff Priorities



	22	24	11	8	3	4	18	15	17	23
MH Staff	60%	42%	72%	37%	44%	50%	31%	48%	45%	34%
MCF Staff	73%	73%	71%	68%	66%	66%	66%	63%	63%	63%

Mental Health - Total # of Responses & % of Total Responses Related to Condensed Codes		
Response	#	%
Code A: Access to Services	64	6%
Code B: Staff Resource Issues	42	4%
Code C: Child, Youth and Family Resource Needs	165	17%
Code D: Review, Analysis or Clarification Required	73	7%
Code E: Clinical Standards	101	10%
Code F: Policy, Organizational Structure, Administration	338	34%
Code G: Service Delivery	91	9%
Code H: Client Population	18	2%
Code I: Information Management	28	3%
Code J: Regional Issues	59	6%
Code K: Concerns External to MCF	9	1%
Code L: Legislation	6	1%
Total	994	100%

MCF - Total # of Responses & % of Total Responses Related to Condensed Codes		
Responses	#	%
Code A - Access to Services	8	5%
Code B - Staff Resource Issues	7	4%
Code C - Child, Youth and Family Resource Needs	26	16%
Code D - Review, Analysis or Clarification Required	3	2%
Code E - Clinical Standards	20	12%
Code F - Policy, Organizational Structure, Administration	66	41%
Code G - Service Delivery	10	6%
Code H - Client Population	4	2%
Code I - Information Management	4	2%
Code J - Regional Issues	13	8%
Code K - Concerns External To MCF	1	1%
Code L - Legislation	0	0%
Total	162	100%

Refer to code descriptions on the following page.

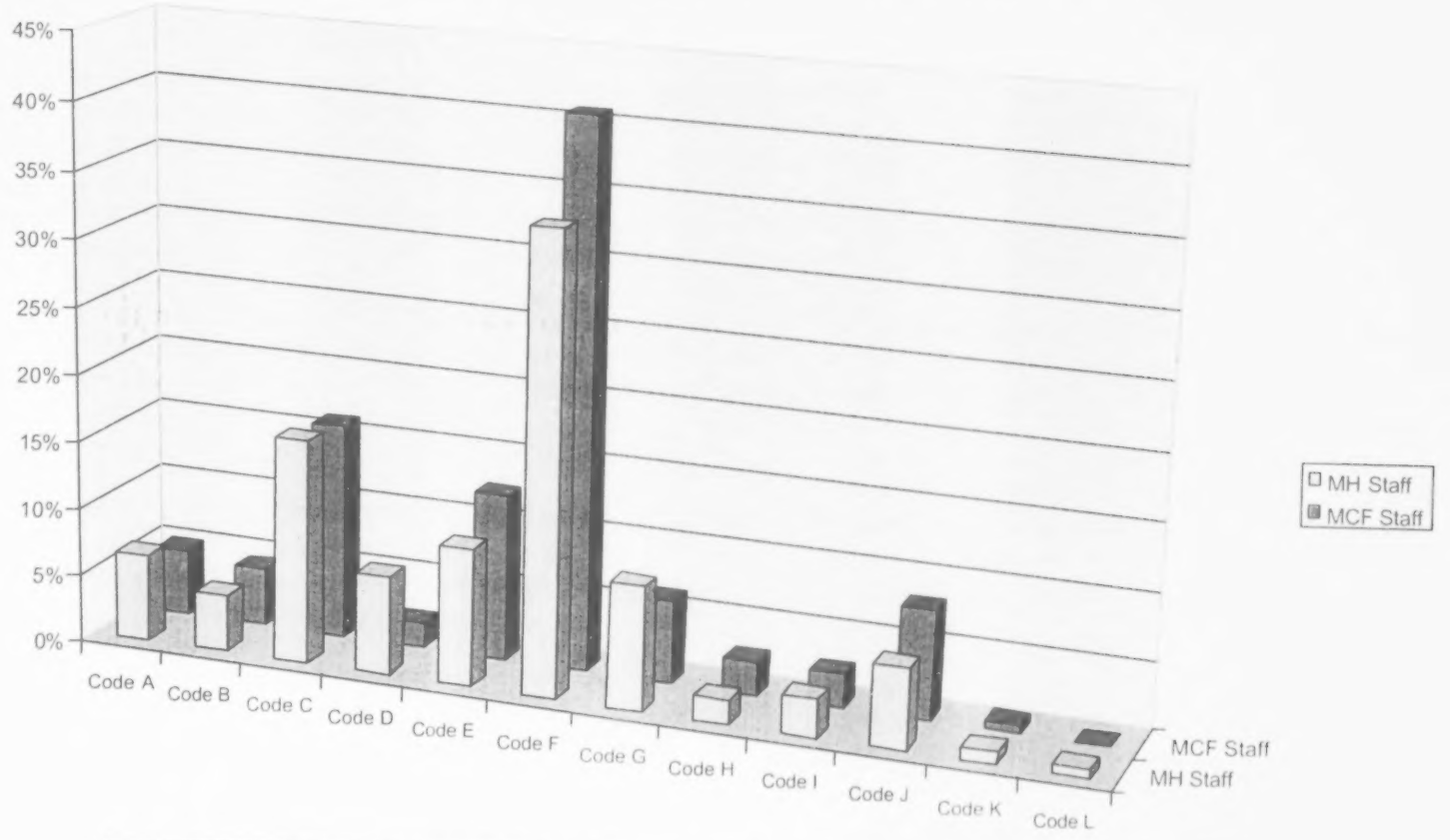
CONDENSED CODE DESCRIPTIONS

Responses/comments were grouped according to the following codes.

Code A: ***Access to Services*** – includes responses related to referral processes, availability of services, barriers to access.
Code B: ***Staff Resource Issues*** – includes workload issues, hiring practices, compensation, training needs.
Code C: ***Child, Youth and Family Resource Needs*** – includes gaps in service, additional resources required related to existing services.
Code D: ***Review, Analysis or Clarification Required*** – includes responses related to use of language that was unclear, issues that needed further discussion or consideration, need for supporting statistics.
Code E: ***Clinical Standards*** – includes clinical supervision, standards of practice, professional qualifications, specialized education.
Code F: ***Policy, Organizational Structure, Administration*** – includes issues requiring organizational, structural, or administrative support and/or change i.e. structure of CYMH teams across regions, lines of communication and accountability, model of service delivery, development of new services.
Code G: ***Service Delivery*** – includes responses pertinent to the direct provision of services to children, youth and families i.e. client therapist relationship, treatment approaches, clinical assessment, cultural sensitivity.
Code H: ***Client Population*** – includes comments related to the identification of the client groups who receive or should receive service from CYMHS staff.
Code I: ***Information Management*** – includes responses regarding the sharing of client information, the development/use of electronic information systems, client consent.
Code J: ***Regional Issues*** – includes issues that require consideration based on regional needs i.e. variable needs for service in rural vs. urban communities and based on cultural representation.
Code K: ***Concerns External to MCF*** – includes responses about issues that fall under the authority of other Ministries.
Code L: ***Legislation*** – responses specific to legislative issues.

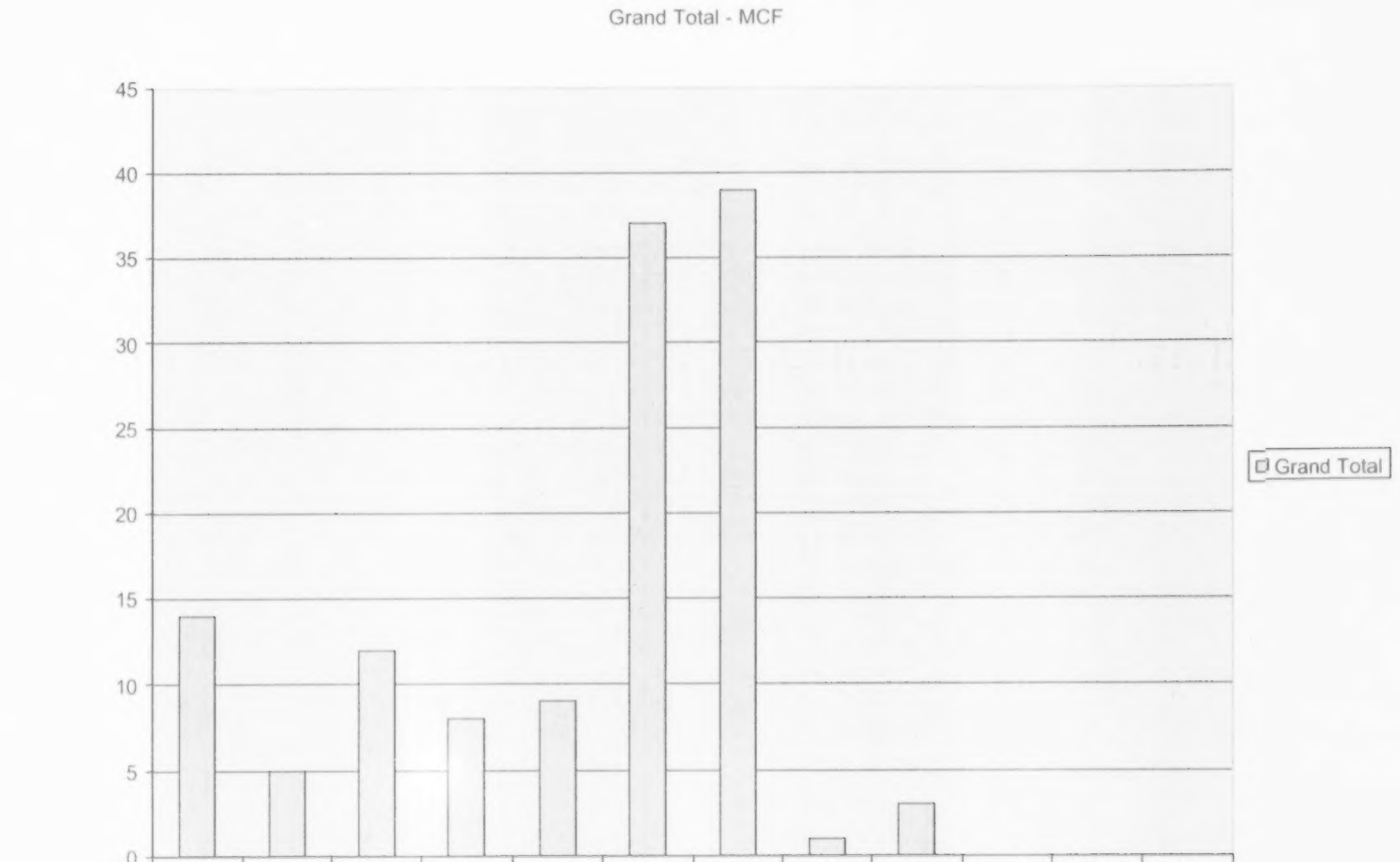
MH and MCF Staff Responses to Directions Document Related to Condensed Codes

(Refer to code descriptions on the previous page in Appendix H)



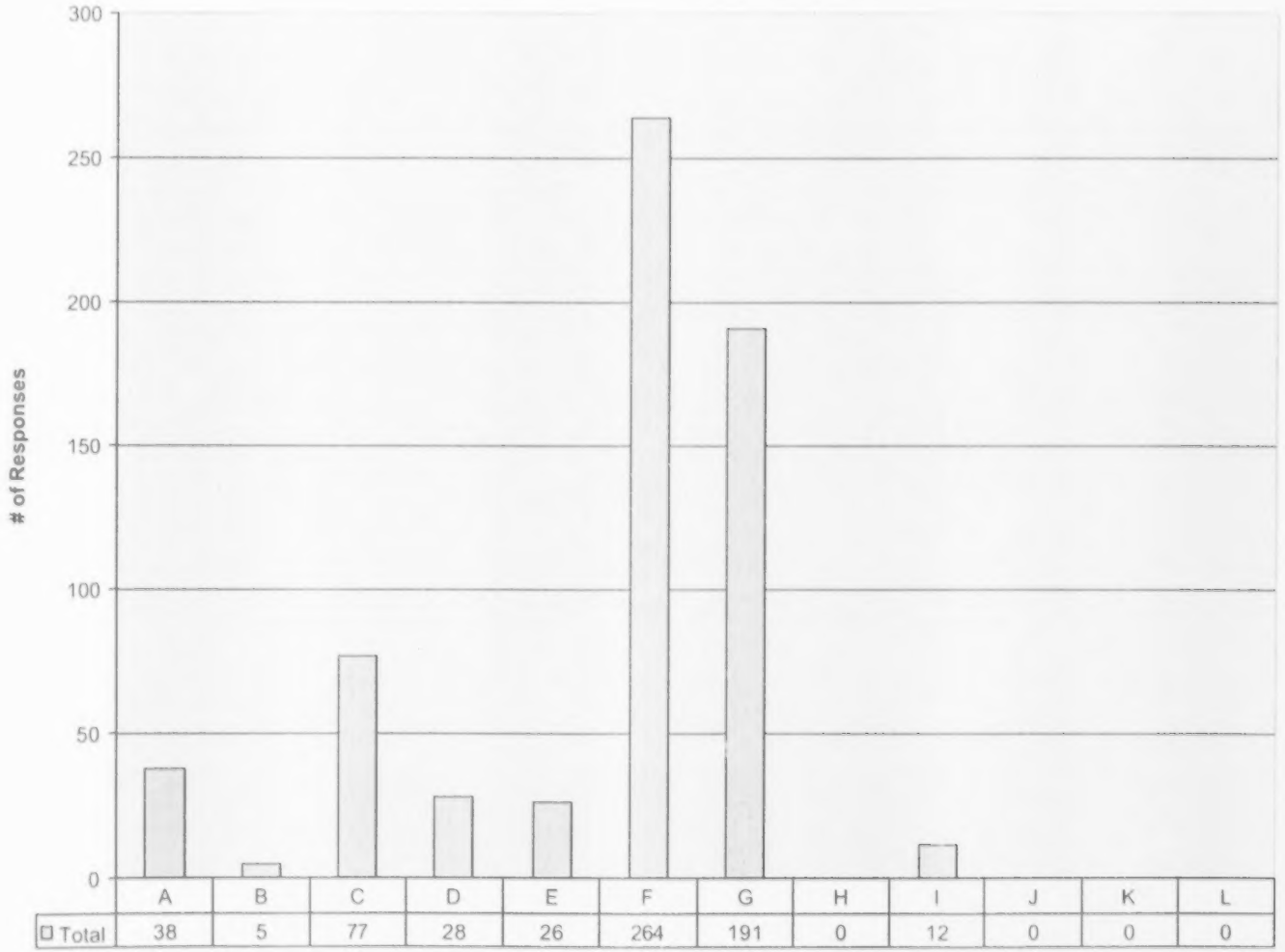
	Code A	Code B	Code C	Code D	Code E	Code F	Code G	Code H	Code I	Code J	Code K	Code L
MH Staff	6%	4%	17%	7%	10%	34%	9%	2%	3%	6%	1%	1%
MCF Staff	5%	4%	16%	2%	12%	41%	6%	2%	2%	8%	1%	0%

Comments From MCF Across Program Staff Focus Groups Related to Condensed Codes (*See code descriptions in Appendix H)*



	A	B	C	D	E	F	G	H	I	J	K	L
Grand Total	14	5	12	8	9	37	39	1	3	0	0	0

Broad Spectrum Focus Group Responses Related to Condensed Codes



	A	B	C	D	E	F	G	H	I	J	K	L
Total	38	5	77	28	26	264	191	0	12	0	0	0

Refer to Appendix H for condensed code descriptions.

REPORT
TO
MINISTER OF
CHILDREN AND FAMILY DEVELOPMENT
MINISTER OF HEALTH SERVICES
MINISTER OF STATE FOR MENTAL HEALTH
AND
EXTERNAL ADVISORY COMMITTEE

PREPARED
BY
JOINT MINISTRY WORKING GROUP

May 10, 2002

Background

In the summer of 2001, the Deputy Minister to the Premier, Mr. Ken Dobell, in co-operation with the Deputy Minister Chris Haynes (Ministry of Children and Family Development and Deputy Minister Leah Hollins (Ministry of Health Services) undertook a review of mental health services for children and youth. The outcome of the review highlighted the need for three tasks to be accomplished before services to children, youth and families challenged by mental illness could be improved:

- Development of a "Child and Youth Mental Health Plan" and accompanying resource plan. The plan needed to contain an 'blueprint' that was based on current research and innovation that served to improve services to children, youth and families.
- Development of policy and protocols to assist youth in making a transition from the child and youth mental health system into the adult mental health system.
- Development of policy and protocols to assist children and youth in being transferred between the community mental health system and the acute/institutional care system.

Mandate and Membership

In order to accomplish the last two tasks the Ministries established a Joint Working Group (JWG) in the fall of 2001. It was required to report on its ongoing work to the Minister of State for Mental Health and the Ministers for Children and Family Development and Health Services. In addition the JWG was required to make a final report to an External Advisory Committee that was established to provide advice to the two ministries on the Child and Youth Mental Health Plan and future directions.

The role of the JWG was to provide advice and project support to Headquarters staff in the two ministries in relation to the development of policies, guidelines, protocols and recommendations for youth transitioning from the child- to the adult-serving mental health systems, and children/youth under 19 years transitioning to/from hospital and community mental health services. (See Appendix 1 for the Terms of Reference and Membership Structure)

Meetings

The JWG met on a monthly basis from October 2001 through April 2002. A Hospital-Community Task Group, established by the JWG in February 2002, met via teleconference on four occasions. This later group provided recommendation to the JWG on key issues involved in the development of crisis/psychiatric response services for children and youth.

Activities

Based on extensive internal discussions, selective stakeholder consultations and support activity from an assigned contractor, the JWG has completed the following work:

Youth Transitions

- Working with the two Ministries, a MCFD Policy Directive and an equivalent MOHS Policy Statement (MOHS) were developed. The MCFD Policy Directive on Youth Transition Services was released to the regions effective April 1, 2001. The MOHS Policy Statement on Youth Transition Services will be released shortly. The policies emphasize the need to begin transition planning and services as early as a youth's 17th birthday. The policies also identify the need for collaboration between the two Ministries and other stakeholder ministries to ensure integrated transition service planning, and the development of service protocols that also address dispute resolution procedures that include youth and their families. (See the two ministry policies in Appendix 2)

- To assist the regions in implementing the services for transitioning youth at local and regional levels, the JWG has developed two related documents.

  - Part I, *Development of Youth Transition Services: Introduction and Concepts*, addresses background concepts relating to the development of youth-centred services and protocols. It identifies some broad as well as more systemic and clinical policy considerations that have been identified by mental health planners to address comprehensively the needs of transitioning youth with serious emotional problems. The document also lists the JWG recommendations regarding future task groups or 'tables of discussion' that could assist regions in the regional development of transition services. (See Appendix 3 and the Recommendations section below)

  - Part II, *Guidelines for the Development of Youth Transition Protocols*, provides practical guidelines for protocol development at community and regional levels, including a template to guide regional managers in writing a protocol. (See Appendix 4)

Hospital-Community Transitions

The JWG has recognized that the challenges in developing effective hospital-community partnerships in the area of mental health are complex. Significant progress can only be achieved through a long-term commitment by both sectors to implement some fundamental changes in the coordination and integration of services. As emphasized most recently by regional health stakeholders in the consultation process undertaken in 2000 by the Ministry for Children and Families on child and youth mental health services:

> *"Cooperation between ministries requires more than just policies being developed – it requires a cultural attitude toward working together to link Adult Mental Health and Child and Youth Mental Health, hospital and community."*

- In order to establish a meaningful analysis of some broad issues in this area, the JWG undertook to address a core service area that concerns both the hospital and community-based mental health service sectors. The area of concern chosen involves local and regional crisis/psychiatric response services, referred to as the *Crisis Response System*. The JWG has developed three documents to address issues relating to the Crisis Response System.

  Part I, *Crisis/Psychiatric Response System: Introduction and Background Concepts*, addresses some key aspects of a Crisis Response System that includes both the hospital and community-based sectors as essential partners in the development and ongoing provision of coordinated/ integrated services along a continuum of care. (See Appendix 5)

  It is acknowledged that while the coordination/ integration of crisis/ psychiatric services is a necessary condition in the delivery of effective and efficient crisis services, it may not be a sufficient condition to ensure positive outcomes for children and youth. The development of evidence-based programs and clinical services is an additional factor that must be urgently considered. This latter issue will be addressed in the Child and Youth Mental Health Plan.

  - Part II, *Crisis/Psychiatric Response System: Recommendations*, follows from Part I and provides eighteen recommendations that focus on the planning and development of a continuum of services that are required at local, sub-regional and regional levels. In addition, the recommendations address regional and provincial/ regional structures or mechanisms required to ensure the successful implementation, coordination, integration, monitoring and evaluation of crisis/ psychiatric services. (See Appendix 6 and Recommendations section below)

  - Part III, *Crisis/Psychiatric Response System: Regional Resource Profile Review*, provides worksheets to enable Regional Health Authorities and Regional MCFD Offices, to establish their short, medium and longer-term priorities. Not every community or regional service area is able to support a complete continuum of services. Each local community can review its current crisis response services in terms of their intended purpose and also decide what other services are of highest priority for development given the community's unique combination of geography, demographics, needs and current local and extra-local services. (See Appendix 7)

Recommendations

Based on the JWG discussions, documentation activities and select input from the Ministries and other stakeholders, the following recommendations are provided to the Ministries and the External Advisory Committee for consideration:

General

1. That the Ministries[1] establish a formal Provincial Child and Youth Mental Health Network with responsibility to ensure an overall system accountability that includes coordinated planning and service delivery, locally, regionally and provincially.

2. That while the responsibility for the provision of formal mental health services lies primarily with the two ministries, any formal planning processes by provincial and regional planners and managers must include the Education system and other ministries serving children and youth.

3. That all five documents prepared by the JWG be made available to the Regional Health Authorities and regional MCFD Offices to facilitate any regional planning processes relating to the development of youth transition services and hospital-community connections.

4. That the Ministries undertake to establish a core provincial data set that captures key input and output variables to enable an annual evaluation of the amount, type and continuity of services for children and youth being served by the hospital, medical and community mental health systems. The current information systems are incomplete and inadequately defined for this purpose.

Youth Transition Services

1. That the Ministries, working with the regions, undertake the development of broad standards of practice for transitioning youth based on accepted values, service principles and evidence-based research.

2. That the Ministries, working with the regions, develop broad transition service access criteria that are mutually acceptable to the child- and adult-serving systems and based on a combination of diagnostic and functional impairment information. Further, that there be an identification of functional impairment assessment tools that can assist regions in assessment, clinical decision-making and outcome evaluations.

3. That the Ministries, working with the regions, identify evidence-based programming options to facilitate long-term regional service planning for transitioning youth with serious mental health problems.

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[1] Any reference to 'Ministries' assumes that the two Ministries, MOHS and MCFD, will be working together in a collaborative fashion with relevant Ministries.

4. That the Ministries, working with the Ministry of Community, Aboriginal and Women's Services and the regions, develop a strategic plan to address residential/housing needs for youth 16 to 24 years who have serious mental health problems.

Crisis/Psychiatric Response System

The JWG has developed detailed recommendations to provide a general direction for communities and regions in assessing the strengths and weaknesses of their current care system and in developing their Crisis Response System plans and priorities within an overall short-, medium, and long-term strategic blueprint. The following is a summary of the detailed recommendations that are described in Appendix 6.

1. That Regional Health and MCFD Offices establish or strengthen a partnership structure or planning body to assist communities in the development of crisis response services and rational points of service entry, service agreements, case management processes, and client-tracking mechanisms to ensure the delivery of comprehensive, continuous and accountable care.

2. That Regional Health Authorities and Regional MCFD Offices develop or strengthen their continuum of crisis services ranging from entry-level and home-based crisis services to regional residential/hospital services that place special emphasis on crisis stabilization and short-term assessment and treatment (STAT) services.

3. That Regional Health Authorities and regional hospitals with acute psychiatric care beds and general medical pediatric care beds review the need for a response capacity for transition-age youth and younger children with acute psychiatric/ emotional disorder.

4. That Regional Health Authorities and Regional MCFD Offices develop or strengthen non-hospital based crisis residential services through collaborative initiatives between the Adult Mental Health Services and the MCFD network of residential resources.

5. That Regional MCFD Offices establish or augment specialized personnel (e.g. hospital liaison workers) to improve the coordination and continuity of care between the regional hospital and community-based mental health service systems.

6. That Regional Health Authorities and Regional MCFD Offices, working with tertiary facilities, establish referral priorities and procedures via a body or mechanism that reflects all stakeholder interests including schools, child and youth mental health, local hospitals and private practitioners.

7. That Regional Health Authorities and Regional MCFD Offices undertake an active public education program to promote high consumer and service provider awareness of the range of crisis services including the appropriate entry points.

8. That Regional Health Authorities and Regional MCFD Offices ensure that designated staffs (including family practitioners and other key hospital and community-based agents) have access to evidence-based practices information and the clinical training needed for child and youth crisis work, including decision options based on provisions of the relevant Acts.

9. That Regional Health Authorities and Regional MCFD Offices identify the potential service contributions of a wide range of private practitioners (especially family physicians) and their linkages with the public sector, and explore the use of video-conferencing technology and other creative approaches as a vehicle for consultation and backup to communities with few resources.

10. That, as part of the formal Provincial Child and Youth Network, the MOHS and the MCFD establish a provincial body or mechanism to work with the regions to coordinate the planning of hospital-based services in order to achieve a coherent and efficient distribution of primary, secondary and tertiary child psychiatric care.

11. That the MOHS and the MCFD, in collaboration with the regions, establish outcome indicators and assessment tools that are tied to best practices for specific crisis response services along the continuum of care.

12. That the MOHS and the MCFD, in collaboration with the regions, specifically monitor the implementation of the Crisis Response System including outcomes for children and youth over a three-year period of regional/provincial planning and regional service implementation.

Concluding Comments

The Joint Working Group was comprised of a cross-section of representatives from the Regional Health Authorities, Regional MCFD Offices, provincial Ministries of Child and Family Development, Health Services and Education, in addition to representation from the Ministers' Offices, family and youth advocates, community physicians and the BC College of Physicians. Three additional representatives were added from the regional acute care sector to assist in the development of recommendations relating to the ongoing development of the crisis/psychiatric response system that includes both the hospital and community service sectors as key partners.

The joint Chairs were impressed with the degree of knowledge and focussed input from the members of the working group on the topics of concern. Throughout the project's six-month term, the discussions were vigorous, with group consensus reached on all major issues leading to the formulation of the recommendations provided in this report. The joint Chairs wish to thank all participants for their contributions towards a better system of mental health care for children, youth and their families.

Jayne Barker, Director
Mental Health & Youth Services
Ministry of Children and Family Development

Cliff Cross, Adult Mental Health Manager
North Okanagan Region
Interior Health Authority

List of Appendices

Appendix 1 – Terms of Reference and Membership Structure

Appendix 2 – MOHS Policy Statement and MCFD Policy Directive

Appendix 3 – Part I, Development of Youth Transition Services: Introduction and Background Concepts

Appendix 4 – Part II, Guidelines for the Development of Youth Transition Protocols

Appendix 5 – Part I, Crisis/Psychiatric Response System: Introduction and Background Concepts

Appendix 6 – Part II, Crisis/Psychiatric Response System: Recommendations

Appendix 7 – Part III, Crisis/Psychiatric Response System: Regional Resource Profile Review

Ministry for Children and Family Development
Strategic Shifts

In 2001, the ministry reviewed its mandate, services and programs to ensure that they were focused to meet government's economic, fiscal and social objectives. The result was the identification of six key strategic shifts:

1. **To open, accountable and transparent relationships.**
   The first strategic shift involves a more open and transparent relationship with staff, the media, community partners and the public. Many people viewed the previous ministry as one with a closed, reactive and defensive culture and a negative relationship with the media. This shift supports front-line workers by allowing them to be more consultative in their approach to supporting children and families.

2. **To enabling communities to develop and deliver services within a consolidated, coherent, community-based service delivery system.**
   The second strategic shift identifies characteristics of the current system that need change. In the past, government has tried to build large, standardized, bureaucratic responses to challenges that exist at the individual and community level. Social programs that are delivered locally, wherever possible, in ways that best reflect the community's needs and strengths are more likely to achieve positive, effective results.

3. **To making strategic investments in capacity and resiliency building and providing funding for programs and services known to work. Capacity, in this context, means ability and potential. Resiliency is the ability to recover from challenging situations. The ministry believes that individuals, families, and communities have the capacity to successfully face and overcome challenges, provided that they are given the opportunities and necessary supports to build and integrate this capacity.**
   The third strategic shift sees resources deployed with an outcomes-based approach, with evaluation measures built in. The belief is that funding decisions must result from evidence-based research, and be fully accountable to the public. For example, early childhood development programs are being benchmarked so that progress toward goals can be regularly and publicly accountable.

4. **To promoting family and community capacity to protect children and to support child and family development.**
   This strategic shift sees the ministry investing in building the capacity of families and communities to deal quickly and effectively with challenges in protecting children, and children and family development. Emphasis is placed on recognizing and building on the strengths of families and communities. Consistent with the ministry's vision is the obligation of society to protect children who are abused or in danger. The ministry's responsibility includes providing the least disruptive intervention necessary to advance the safety and well being of the province's most vulnerable children. Better outcomes may be achieved by placements with extended family, long-term family friends or families in the same community.

Strategic Shifts (continued)

5. **To a community-based service delivery system that promotes choice, innovation and shared responsibility.**
   This shift recognizes those who know best what services and supports are required to assist persons with developmental disabilities to independence – the adult, their families, their caregivers and their communities. The ministry believes that the funding for this area could be used much more effectively if the system offered choices to families, to communities, to private and community sector partners.

6. **To building capacity within Aboriginal communities to deliver a full range of services with emphasis on early childhood and family development.**
   This strategic shift sees the ministry investing in building the capacity of Aboriginal families and communities to deal quickly and effectively with challenges in protecting children, and in children and family development. As in other communities, Aboriginal communities must be supported to deliver the full range of services that support their children, families and communities.

As the ministry proceeds with its work, these strategic shifts will guide our plan implementation.

CHILDREN'S MENTAL HEALTH NETWORK

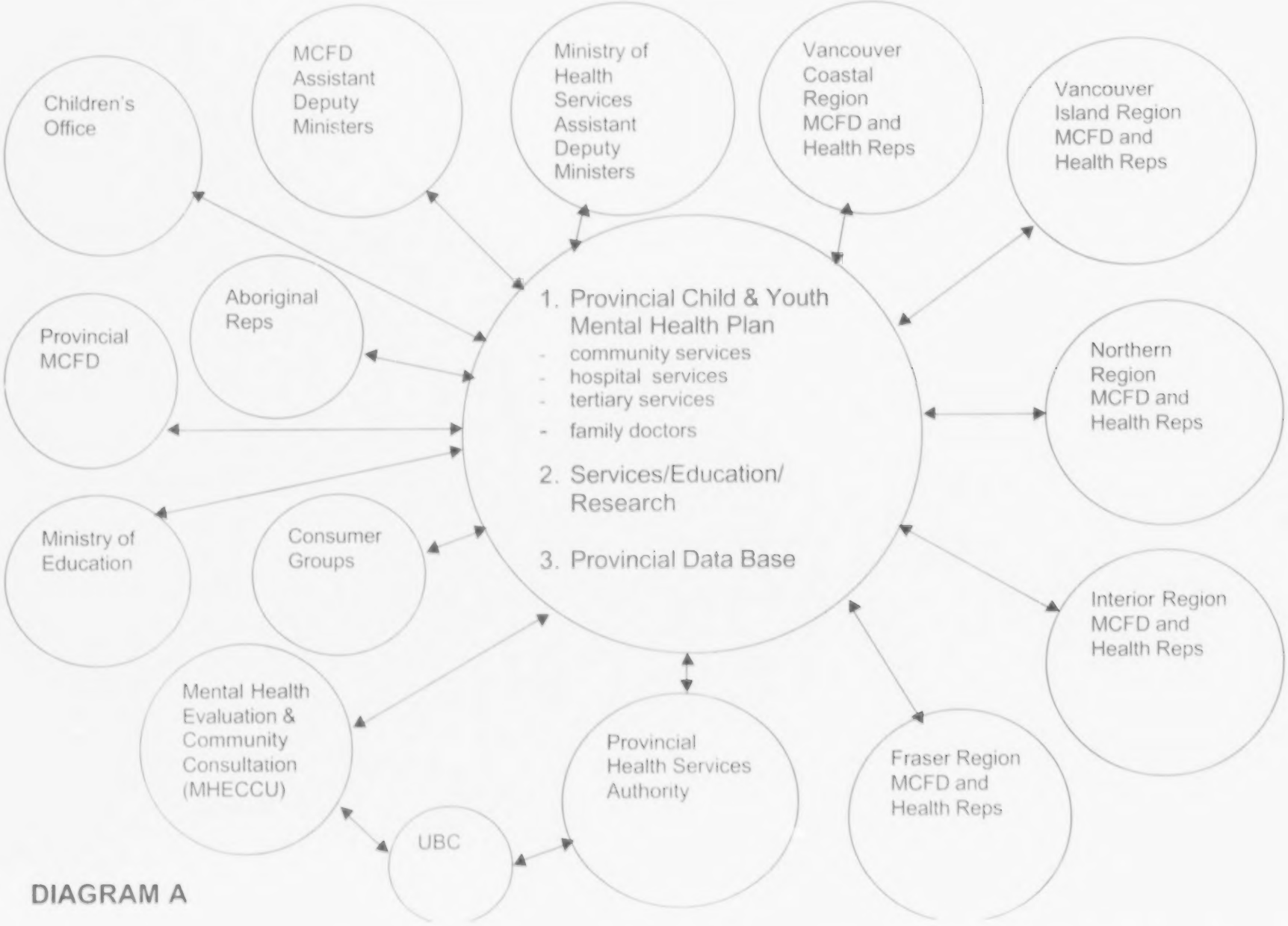
Children's Office
MCFD Assistant Deputy Ministers
Ministry of Health Services Assistant Deputy Ministers
Vancouver Coastal Region MCFD and Health Reps
Vancouver Island Region MCFD and Health Reps
Aboriginal Reps
Provincial MCFD
1. Provincial Child & Youth Mental Health Plan
- community services
- hospital services
- tertiary services
- family doctors
2. Services/Education/ Research
3. Provincial Data Base
Northern Region MCFD and Health Reps
Ministry of Education
Consumer Groups
Interior Region MCFD and Health Reps
Mental Health Evaluation & Community Consultation (MHECCU)
Provincial Health Services Authority
Fraser Region MCFD and Health Reps
UBC

DIAGRAM A

EARLY PSYCHOSIS INTERVENTION

Early Psychosis Intervention is an example of an early intervention strategy. Psychosis is a serious mental health disorder with significant and often tragic personal, societal, and economic consequences when untreated or improperly treated. The onset of psychosis occurs most often in young people aged 13 -25.

Background:

- Delivery of services for youth with early psychosis in BC varies greatly, with some regions being fairly well developed and others having little or no capacity to respond to the needs of these highly vulnerable individuals.
- The delivery of early psychosis services needs to be supported by practices that are evidence-based, an infrastructure that encourages coordinated service delivery, and ongoing research, evaluation, and education.
- Coordination of service is facilitated through the development of policies, transition protocols, and service agreements among service delivery systems.

Rationale:

- Psychotic disorders disrupt a young person's life at a critical stage of social and psychological development.
- Studies show the duration of untreated psychosis is approximately 2 - 3 years. A long duration of untreated psychosis disrupts normal brain development and maturation, and is associated with significantly poorer recovery.
- Identification, early intervention and optimal intervention in early psychosis is associated with:
  - Decreased suicide rates;
  - Decreased need for hospitalization, with ability to remain in their own homes and communities during the recovery process (South Fraser Early Psychosis Program found that 25% of individuals with early psychosis were diverted from hospital in the first year of program; Nova Scotia Early Psychosis Program reports that 80% of those with early psychosis can be treated in the community and do not require hospitalization);
  - Faster and more complete recovery;
  - More rapid re-integration with return to school or work;
  - Reduced risk of developing secondary psychiatric conditions and other problems, e.g., addictions, criminal activity, family distress; and
  - Reduced risk of victimization (street culture, sexual exploitation).

Components of Early Psychosis Intervention

- Depending on population base, geographic location and resources, early psychosis services may include all or some of the following components.

Service models for rural areas of the province will differ substantially from more urban areas, and may include use of speciality outreach services as well as use of telehealth.

- Through partnership between the Ministry of Children and Family Development and the Ministry of Health Services, training for 7,000 people was completed including gatekeeper training in identification of the early signs and symptoms of early psychosis, and clinical skills building targeted at physicians and mental health clinicians to enhance skills in assessment, diagnosis and optimal treatment.
- Identification and risk management will be provided for individuals who are at high risk of developing a psychotic disorder in the near future (based on schizotypal personality disorder and recent change in mental state, sub-threshold psychotic symptoms occurring several times a week over at least a week, or brief intermittent psychotic symptoms).
- EPI practitioners will work with community service providers such as primary care and family physicians, to assist in assessment, monitoring, support and referral. Risk factors may be reduced by enhancing coping strategies which may delay or prevent onset of psychosis (e.g., decreased stress, avoidance of substance use).
- EPI Committees currently exist in some regions. Regions without these committees will be encouraged to develop a mechanism to review current service delivery systems and referral processes.
- Coordination and provision of services for young people aged 13 – 19 with early psychosis will include linking with the adult serving mental health system through transition protocol agreements currently being implemented in the regions. The services provided through EPI will complement the Ministry of Health Service's Early Intervention Initiative for individuals with serious mental health disorders.
- As regional resources allow, EPI services may include outreach, assessment, treatment, case management, support and educational groups for client and family, crisis and respite capacity, and reintegration into the community.
- An EPI Care Guide on best practices in early psychosis is being developed by MHECCU to provide guidance to practitioners in the field. Training in the use of this guide will facilitate its appropriate use.